Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lend #5 Per FH G938 4/23/2013 JH
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 0940 Morris G. Fluharty, Sr. 2012 October Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Caroline Caroline Nursing Home Denton Birthplace (State or Foreign Country) Social Security Number 218–24–4058 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Hours 1 □XM 2 □ F Months Days Director 1930 Maryland Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State the Maryland Director or 28a-f sh notified a 1 S Yes 2 No Caroline Denton 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ō must be r Funeral Page 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a United States 21629 520 Kerr Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White 3 ₩ Widowed 4 Divorced Completed Shows ...
h and Mental Hygiene.
27 is marked other than "natural" Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter/Roofer 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur C. Fluharty Mary Patrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wesley Cohee/Friend PO Box 580, Preston, MD 21655 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite 1 X Burial 2 Cremation 3 Removal from State injury or Junior Order Cemetery 10/27/12 Preston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. any ir Phristine 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final disease or condition 2000-66 Physician/ Inne Concer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ■ Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 🗌 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 28c. Injury at work?
1 Yes 2 No 28b. Time of 27. Manner∞of Death 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation Could not be Accident 3 Suicide 4 Homicide 6 🗆 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number CIM 10/03/2012 Do053255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N

DHMH 17 Rev 7/2009

State

Registrar

ORIGINAL

3683 Croptonk

32. Registrar's Signature

Butter

26 2012

31. Date filed (Month, Day, Year)

MD 21655

Pressa

2-08332 aith Ann Griffin		Please Type or Print in Black Indelible State of Maryland / Department Certificate	of Health and Mental Hy	giene	201	2 3700
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,Last)		Reg 2. Date of Death		3. Time of Death
ledical Examir	ner	Faith Ann Griffin		Month I November 3		2118 hrs
		4a. Facility Name (if not institution, give street and number) Meritus Medical Center	4b. City, Town, or Location of Death Hagerstown		4c. County of Deat Washington	n
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. Months Days Hours Min.		(MM/DD/YYYY) 9. Bi Forei	
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits
*	5	Maryland Washington Boonsb	oro			1 Yes 2 X No
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shounatic event, the Medical Examiner must be notified at once	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	intry?
ith the 23a or		7870 Mountain Laurel Road	21713		U.S.	
eath wi	Funeral	1 X Never Married 2 Married Armed Forces?	Vas Decedent of Hispanic Drigin? (Spo Yes, specify Cuban, Mexican, Puerto I		14. Race - Ame White, etc.	rican Indian, Black,
fter de	by Fu	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify:		Specify: Whi	te
nours a		15. Decedent's Education (Specify only highest grade completed) 16a. Decedenting	ent's Usual Occupation (Give kind of w most of working life, DO NDT use retire		6b. Kind of Business	/Industry
36 in 72 h	Be	Elementary/Secondary (0-12) College (1-4 or 5+)			D 11: 0	1 1 0
MD 21215-0036 12 should be filed within 72 th and Mental Hygiene 27 is marked other than '	Completed	11 17. Father's Name (First, Middle, Last)	Office Manager 18.Mother's Name	(First, Middle, Ma		hool System
be file	å	Morgan L. Griffin, Jr.	Ruth E.	Burroug	hs	
D 21 should and Me	유		ng Address (Street and Number or R			
more, MD 2 ages I and 2 shoul ant of Health and M nt: If item 27 is in rother traumatic	-	Ruth E. Griffin/Mother 787 20a. Method of Disposition 20b. Place of Disp	O Mountain Laurel osition (Name of cemetery,		oonsboro. 20c. Location - City o	
DOFE ages 1 at of H t: If i		1 Burial 2 X Cremation 3 Removal from State crematory or		/07/10		
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If iten 27	ł		er Crematory 11, Name and Address of Facility Bas	t-Stauf	fer Funera	, Maryland
De De De		Randall L. Weagley- MOO759 Per DVR 76	06 Old National P	ike, Boo	onsboro, M	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac or	respiratory arrest	t, shock, or heart	Approximate Interval Between Onset and
xaminer	ĺ	Immediate Cause (Final disease or condition resulting in death) A Narcotic (Morphine) Due to (or as a consequence of):	Intoxication			Death
वर		Sequentially list conditions, b				ļ
	<u>ē</u>	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				1
2 2 2	— L	d. #21 \$1 22-	-+ TT 27 200 £		25 1 25 12	<u> </u>
ox 68760, eath certificate be execut attending physician and or use as the burial - tra	Physician/Medica	X UNPENDED X AMENDED #21, per fh, 23a	,pt.11,2/,20a-1,po	er me,g9		
Box 68760, e death certificate be the attending physici ed for use as the burn	<u>₹</u>	F FEMALE: 38. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 3 1 Live birth 2 1	Fetal death 3 Ectopic pregnar	псу	23d. Date of deliver Month	y Day Year
ox 6 ath cer attendi	흥	4 Pregnant at time of death 5	Other (Specify)			
D & 8 8	ᇎ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
- 85 gg ea	٦	congestive heart failure due to car	diac fibrosis;	1 Yes	2 No 3 Pro	bably 4 Unknown
ords w requir	Completed	chronic obstructive pulmonary disea	se:hepatitis C	24a. Was an autopsy		utopsy findings available completion of cause of
eco he law ate has	E			perform 1 Y Yes 2	ed? death?	
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	26.Place of Death (Check o	nly one)		
	의	1 Yes 2 No Inpatient 2 V ER/Outpatie			esidence 6 Othe	r:
ding h.		27. Manner of Death 28a. Date of Injury 28b. Time of 1 Natural 5 Pending 2 1.11.3 1.2 5 1.00	1 Yes 2 X No. S		w injury occurred took drug	
rision r Atter	ق	2 X Accident Investigation 28e. Place of Injury - At home, farm, str	30 am	28f. Location (Stre	eet and Number or Ri	ural Route Number, City It Laurel Rd.
Div	Certification:	4 Homicide determined (Specify) Resider		or Town, Stat Boonsbor		t Laurel Rd.
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Salc	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ				
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated, 29b. Signature and title of certifier	ation, in my opinion, death occurred at		d place, and due to the signed (Mo	
02		All Man	O.C.M.E.		November 5, 20	
021	-	30. Name and address of person who completed cause of death (Item 23a)				

DHMH 17 Rev 1/2001 DCME 2006

State Registrar Melissa Brassell, MD

32. Pegistrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

2-08271		Please Type or Print in Black					V	0 7 0 0
effrey Green		Kegistrar		ent of Health ar ate of Death	nd Mental F		201 leg. No.	2 3700
Physici ledical Exam		1. Decedent's Name (First, Middle,Last) Jeffrey Wayne Green	_			2. Date of Dea Month Novembe	Day Year	3. Time of Death 1935 hrs
		4a. Facility Name (if not institution, give street and number) 1014 Brinker Drive # 102		4b. City, Town, o	or Location of Deal	h	4c. County of De Washington	ath
Funeral Director		217-78-5108 1 _X M 2_F	yrs. last birth	Months Da			1961 (MM/DD/YYY)	Birthplace (State or eign Country Mary Land
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Directo		city, Town		ispanic Origin? (9		U.S.A.	10d. Inside City Limits 1 X Yes 2 No puntry?
s after death w iral", or item	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 N 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed	No	If Yes, specify Cuba 1 Yes 2 X N Decedent's Usual Occup.	an, Mexican, Puert o s <i>pecify:</i>	o Rican, etc.)	White, etc.	lack
1036 vithin 72 hour ene ritan "natu Medical Exan	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2 2	°	during most of working lif	e DO NOT use re	tired)		Virginia
21215-0036 wild be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, Last) Robert Claude Green				e (First, Middle, dna May	Maiden Surname) Yates	
212 hould b ad Meni is mari	ם	19a. Informant's Name/Relationship (Type, Print)	19b	. Mailing Address (Stre				ite, Zip Code)
, MD and 2 sho earth and em 27 is		Linda O. Green - wife 20a Method of Disposition 12		014 Brinker f Disposition (Name of co		pt 102,	Hagerstown	
Baltimore, Dermit. Pages I an Department of He Important: If ite		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	cremato	ory or other place) Hill Cemete	ry Nov	ember 2012	Hagersto	wn, Maryland
Ball permit Depart Impor		21. Signature of Funeral Service Licensee		22. Name and Addres			Funeral Ho	me Maryland 217
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Athero		t enter the mode of dying	g, such as cardiac			Approximate Interval Between Onset and Death
/- Xu		or condition resulting in death) Due to (or as a consequence	ce of):					
	Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated						
executed an and al - transit	cal Exa	events resulting in death) Last Due to (or as a consequence d.	ce of):					
		UNPENDED AMENDED					Terrar and	
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be every. After this certificate has been signed by the attending physicial by the funeral director, page 2 should be detached for use as the buria	Physician/Med	IF FEMALE: 13b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of past 12 Live birth 4 Pregnant at time of past 12 months?	2	Fetal death 3 Other (Specify)	Ectopic pregn	ancy	23d. Date of delive	ary Day Year
i, P.O. E ires that the signed by the	ρ	Part II. Other significant conditions contributing to death but n Obesity	not resulting	in the underlying cause	given in Part I.	_	obacco use contribute s 2 No 3 Pr	to the cause of death?
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ital Redicion: The scertificate irector, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	ER/O	26.Plac tpatient 3 DOA	of Death (Check		Residence 6 🗸 Oth	or Score
on of V ading Phys th. After thi e funeral di	ion: To	1 ✓ Yes 2 No Inpatient 2 27. Manner of Death 1 ✓ Natural 5 Pending 1 ✓ Pending		ime of Injury 28c. Injury	ury at Work?		how injury occurred	er, gcerie
Division Hospital or Attendi 24 hours a er deat. Funeral Director	Certification:	2 Accident 3 Suicide 6 Could not be determined (Specify)	At home, far	rm, street, factory, office		28f. Location (or Town, S		Rural Route Number, City
To the Hos within 24 h To the Fun completely	Medical (29a. Certifier 1 Certifying Physician: To the best of my know one) 2 Medical Examiner: On the basis of examination and manner stated.						
F 3 H 3	Me	29b. Signature and title of certifier	7		se number		29d. Date signed (M	
		30. Name and address of person who completed cause of death (I Melissa Brassell, MD Assistant Medical Exal		900 W. Baltimore S	Street, Baltimo	ore, MD 2122	23	
St Regis		31. Date filed (Month)	nature	ball				

Registrar

OCME

			Plea	se Type or							-		_	ible.			
		For State		State of	Marylar					and N	/lental Hy	gien	e an	10	27001		
		Registrar 1. Decedent's Name	a (First Middle	l act)		Cer	tificat	te of E)eath			Reg. N	10. <u>U</u>	16	3/004		
Physicia Medic	al	Goldi	ie Lor	raine Gl	adhill						2. Date of Death Month Day			Year 1012	3. Time of Death Q: 25 TM		
Examin	er 	Meritus	s Medic	al Center				Hager	Location of stown	n		\perp	c. County Wash	ingt			
Funeral Director		5. Social Security Number 219-14-8622 1 M 2 X F 88 Yrs. T. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10 Ctober 6, 1924							1924	9. Birth	place (State or Foreign aryland						
und show at	'n	Usual Residence of 10a. State	10b. County		10c. Ci	ity, Town or Lo	cation	1		1	l			1	10d. Inside City Limits		
Maryla 28a-f s atified	Director	Maryland Washington Hage													1 X Yes 2 No		
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ath wil	Funeral	78 Sunk	orook L	.ane	lent Ever in II	S 13 \	Nas Dece	2174		gin? (Sne	U.S.A. ecify Yes or No-			oon Indian			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	Marital Status Never Marri Widowed		ried Armed Ford	ces? 2 X No		 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify: 					Black, White, etc. Specify: White			etc.		
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nd Me s mari		19a. Informant's Na			10.0	19b. Mailir	ng Addres	ss (Street a		entt. er or Rura	ie May al Route Numbe		enry or Town, S	tate, Zip (Code)		
and 2 sl Health a em 27 is		William	R. Gla	dhill Jr.	Husbar	n d 78	Sunb	rook	Lane	, Ha	gerstow	n, I	Maryl	and_	21742		
Page 1 al ment of H ant: If itel ury or oth		20a. Method of Disp 1 Derial 2 2 4 Donation	Cremation	3 ☐ Removal from Specify)	24-4-	Place of Dispo cemetery, cren gerstow	natory or	other place	e) Dry :		Date 5-12		Location - gerst	•	own, State Maryland		
permit. Departr Imports any inji		21. Signature of Fur	neral Service L Loel	Brade	r	2A 4	ndre 0 Ea	w ^{d A} K ^{dres} st Ar	Coff	man am S	Funeral treet,	Hor Hage	me, I ersto	nc.	Md. 21740		
Physician/		23a. Part 1. Enter the shock, or hear Immediate Cause (I disease or condition)	Final	complications that and an account one cause on tack	used the dea h line.	th. Do not ente	er the mod	de of dying	g, such as	cardiac d	or respiratory ar	rest,			Approximate Interval Between Onset and Death		
Medical Examiner		resulting in death) Due to (or as a consequence of):															
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that the	by Pr	Part II. Other signifi	icant condition	ons contributing to de	ath but not re	sulting in the u	nderlying	cause giv	en in Part I	l.	23e. Did to	obacco	use contr	ibute to th	ne cause of death?		
equires een sig iould b	ted										1 🗆	Yes 2	2 🗆 No	3 Prol	bably 4 🛣 Unknown		
sician: The law re certificate has be director, page 2 sh	Completed										24a. Was autor perfo 1 Yes		p		psy findings available mpletion of cause of 2 No		
ician: certific rector,	Be	25. Was case referre		Hospital:				Out-	ace of Deat	th (Check	only one)						
y Physer this eral di	e: To	1 ☐ Yes 2 ₽ 27. Manner of Death	No 1	28a. Date o	f injury	ER/Outpatier 28b. Time of		OOA 28c. Injury	4 ∐ Nu at		me 5 Residence Residence Residence But 5 Residence Resid)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,	Certificate:	1 Natural 2 Accident 3 Suicide	5 ☐ Pendin Investig 6 ☐ Could	pation not be	of Injury - At h	injury ome, farm, stre	M eet, factor		? Yes 2 🗆	\rightarrow	28f Location (5	Street a	nd Numbe	r or Rural	Route Number,		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the f		4 Homicide	determ		g, etc. (Specif	y)			doto ond		City or Tox	vn, Stat	re)				
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Son With		29b. Signature and t	title of certifier	10 A2	2		29	c. License	number	12	Sus Re	29d. D	ate signed	(Month, 1	Day, Year)		
7				who completed cause	of death (Iter	n 23a) (Type, P	rint)		0 0	_	. 0	a 1	1100		21742		
Stat	е	Mohami 31. Date filed (Month	ned t	2012 32.	gistrar's Signa	ature A	led	I.		unf	JUS RE	入.	tag	e (STI	own, MO		
Registra	r	ì	nut V	AU IL		13. 19											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 19-2012 Physician/ Stanley Gerzimbke 05:20 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Transitions Health Care of Sykesvill Sykesville Carrol1 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours Min 1 🛛 M 2 🗆 F 9-23-1936 579-50-9651 76 Poland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified any once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 No VA Alexandria City Alexandria 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 22311 USA 5359 Filmore Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 Yes 2 If Yes, Give Completed by 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Divorced 4 X Divorced Year or Dates. 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Scientist Chemical Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ken Labowitz-Attorney P.O. Box 324, Alexandria, VA 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) November 1, Alexandria, VA 2012 22. Name and Address of Facility Jefferson Funeral Chapel 21. Signatu of Funeral Service 101530 \$755 Castlewellan Dr., Alexandria, VA 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on e.g. line. Approximate Interval Between riset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ment Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Dualto for sels consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and -trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Year ed by the a g Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

Yes 2 No certificate 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this of funeral direction 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No ✓ Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

JM

within 2 To the I

29b, Signature and title of certifie

31. Date filed

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Stone

Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Albert Pershing Granger, Sr. October 21 2012 6:30 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Carroll Hospice Dove House Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year, 705-12-5735 Director 1 X M 2 □ F 94 Sep 27, 1918 Maryland 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "neture!", or Items 23e or 28a-f shorother treumetic event, the Medical Examples must be mutified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Westminster 1 🗆 Yes 2 X No Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21158 2642 Baumgardner Road USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Mamied 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2 No Specify: WWII Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Food Company Sales Representative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frederick O. Granger Ethel Sourwalt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Importent: If Item 27 Is eny injury or other treu 2642 Baumgardner Road, Westminster, MD 21158 Cherie Granger, wife Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 10/25/2012 Finksburg, MD 4 Donation 5 Other (Spertombment Evergreen Memorial 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis St, Westminster, MD 21157 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examine Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burlal-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death 2 No g Unknown 9 Unknown Part II. Other significant conditions entributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by has been sig ge 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed To the Hospitel or Attending Physicien: The within 24 hours after death.

To the Funerel Director. After this certificate completely filled in by the funeral director, pag 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, |@ 1 Yes 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature nd title of certifier 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year Physician/ 4:05 PM Donald Richard Green Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown Meritus Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours 219-72-8737 Director 1 X M 2 🗆 F 42 Yrs Jan 18, 1970 Maryland Usual Residence of Decedent 28a-f show 10a State 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a U.S.A. 21713 21532 National Pike Apartment 2 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. or 1 Never Married 2 X Married þ Maryland 21215-0036 1 Yes 2 No Specify White Specify. "natural", 3 ☐ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Material Handler Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ellen Mae Deatrich Luther Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 21273 Mt. Lena Road Boonsboro, MD Ellen Green / mother or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem Park 11/3/2012 Hagerstown, Maryland 22. Name and Address of Facility Bast-Stauffer Funeral Home, 21. Signature of Funeral Service License 7606 Old National Pike Boonsboro, MD 21713 filons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and on each line. 23a. Part 1. Inter the disease, or complic shock, or heart failure. List only on Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ welk disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a co To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Morbord obesity Records, 1 ☐ Yes 2 ☐ No 3 ☐ robably 4 ☐ Unknown Completed probetese melliture 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hypertension 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Latar Mauk Mn) (Type, Print)

Registrar

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paneld Browsbow MD 47/3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 10:28 PM Jovce LaRue Grove Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hagerstown Washington Meritus Medical Center Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 219-14-7705 Director 1 □ M 2 🗓 F 88 Maryland May 4,1924 28a-f show 10c. City, Town or Location 10b. Count 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Maryland Washington 1 Yes 2 No Hagerstown or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21740 U.S.A. 1183 Luther Dr. items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than, College (1-4 or 5+) Elementary/Secondary (0-12) should be filed within and Mental Hygiene. Department Store Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked Julia M. Snodderly Clarence W. Grimm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13541 Hallowfax Dr. Hagerstown, MD 21742 Richard Snyder-nephew Health item 27 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 11-5-2012 Rest Haven Cemetery Hagerstown, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service License any 1331 Eastern Blvd. North Hagerstown, MD 21742 Kaetlin 23a. Part 1. Enter the diseas c in lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition Onset and Death Physician/ 1000 Medical resulting in death) hous Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine for use as the burial-tran Due to (or as a consequence of): Physician/Medical that the death certificate be IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months? Month Day Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas page 2 autopsy performe death? Yes 2 Ne Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 မ filled in by the funeral 27. Manner of Death 28c. Injury at work? 1 ☐ Yes e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Box 68760

P.O.

Records,

of Vital

Division

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AN ORADE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

3 Time of Death

Physician/ Medical Examiner

1 - State Registrar

Physician/ Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Oct. 0945 Clifford 22, 2012 Rogers Green 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Talbot 28677 Sanderstown Road Trappe If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** . Age (In yrs. last birthday) 9. Birthplace (State or Foreign Director 129-16-9280 Usual Residence of Decedent 1 JM 2 JF 07/31/1925 N.Y. Yrs. 87 or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at **Funeral Director** MD. Talbot 1 🗆 Yes 2 🗶 No Trappe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S.A. death with 28677 Sanderstown Road 21673 items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, an "natural", or iter Medical Examiner Was Decedent Evi Armed Forces? 1 A Yes 2 N If Yes, Give Year or Dates. Black, White, etc þ 1 Never Married 2 XMarried permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinone. Navy 1 Yes 2X No Specify White Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Wilson C. Green Emma Jane Satterly 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code. 21673 28677 Sanderstown RD., Trappe, MD. 21673 19a. Informant's Name/Relationship (Type, Print) Kathleen Green / Wife 20a. Method of Disposition
1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Crem. of Delmarva 10/24/12 Delmar, DE. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Hurley Addes Ostrowski Funeral Home P.A. Ostrowski Box 518 St. Michaels, MD. P.O. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Ischemic cardiomyobathy disease or condition resulting in death) Due to (or as a consequence of): Days myocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be attending phy 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Nown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has le 2 autopsy performed Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ပ 1 ☐ Yes 2 No t Nursing Home 5 Residence 6 Other (Specify)
t 28d. Describe how injury occurred 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No injury 5 Pending 1 Natural 24 hours after death.
Funeral Director: A letely filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCTOBER 23 2012 TUS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q+VA VAIDYANATHAN 2195 WASHINGTONST, EASTON, MD - 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

OCT 2 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month () 1350 M ernon Sraw 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Acelone ! Social Security Number Modical Wicomico Center If Under 1 Year II Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min. 228-42-7008 Director 1 **⊠**M 2 □ F 10-20-1933 Wisconsin permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23s or 28a-f ahow any injury or other traumetic event, the Medical Evantriat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Quinb Clamac 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral Place 9312 Lanz 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White Completed 3 NWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Secondary (0-12) Mcchanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (sraw Hookins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) laverne Accomo Helen 233e i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State 10-24-20121 4 ☐ Donation 5 ☐ Other (Specify) Fairview Lawn Ononcock 21. Signature of Funeral Service Licensee 22. Name and Address of Facility hincotogye, UA 23336 hineral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in a such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) UCar Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospitel or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Yes 2 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medicai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year) HBLO completed cause of death (Item 23a) (Type, Print) UPI 31. Date filed (Month, Day, 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State o	f Marylanc					and M	ental Hy	giene	2012	37011
			State Registrar			Cen	tificate	of De	eath			Reg. No	CUIL	. 07011
	Physicia	n/	1. Decedent's Name (First, Middle, Las	•							Date of Dea Month	Day	y Year	3. Time of Death
	Medic		Wayne Vernon H	olter							0c	t 31	2012	2:12 A M
	Examin	er	4a. Facility Name (if not institution, give	street and num	ber)		4b. City, T	_		f Death			County of Dea	
			125 Lakin Avenue 5. Social Security Number 6. S	1	7 4 // /	4 1 1 1 1 1 1 1 1 1 1	Boon If Under		O If Under 2	24 Hrs T	8. Date of Birt		ashing	ton irthplace (State or Foreign
	Funeral Director			w 2 □ F	7. Age (In yrs. las		Months		Hours	Min.	(Month, Day			ountry)
-			Usual Residence of Decedent	A W Z L F	75	Yrs.					Nov 3,	1936	Ma	ryland
	and shov	io	10a. State 10b. County		10c. City,	Town or Loc	ation							10d. Inside City Limits
	Mary 28a-f otifie	rec	Maryland Washingt	on	Boons	sboro								1 X Yes 2 □ No
	a or be no	<u>0</u>	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What C	Country?
	h with	Funeral Director	125 Lakin Avenue				2171					U.S.		
	r iter		11. Marital Status1 ☐ Never Married2 ☐ Married	A 1 F	dent Ever in U.S. rces?	10	Vas Decede Yes, speci	ent of Hisp fy Cuban,	oanic Orig , Mexican	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		Race - Am Black, Wh	
38	al", o	d by	3 Widowed 4 Divorced	If Yes, Giv Year or Da	rces? 2 No 195; e ites. 1966	8- 1	☐ Yes 2	X No	Specify:				Specify:	White
ŏ	hours natur lical	lete	15. Decedent's E	ducation	1900	16a. Deced	ent's Usua	Occupati	ion	of wordsin		16b. K	ind of Busines	s/Industry
215	is filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-	-4 or 5+)	life. DC	ind of worl NOT use	retired)						
2	y with ygien her ti	Be C		5+					dmin:				cation	
and	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 25a or 28a-f sho to event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, Last)	T = 1 + = ==							(First, Middle,			1 +
2	i and 2 should be filed with fleath and Mental Hygier item 27 is marked other tother traumatic event, the		Daniel Vernon F 19a. Informant's Name/Relationship (7)	lolter		ton Maille	- A -l-l		Helen		nore] Route Numbe	Hoff		olter Zin Codel
Ma	2 sho th an 27 is traur		Sarah Holter / wi			125 L					sboro,		21713	ip code)
é	1 and 2 s if Health item 27 other tra		20a. Method of Disposition	.16		ace of Dispos	sition (Nam	e of	- 1		ate		ocation - City o	or Town, State
JO L	Page 1 ment of ant: If i ury or o		1 X Burial 2 Cremation 3 C			metery, crem Luth		her place)		11/5/	2012	Midd	1etown	, Maryland
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of H Important: If ite any injury or oth		21. Signature of Fundal Service Licen	-)			Address	_					1 Home, P.A.
m	a m De		1 HOW COS	Tagery	0	100					ike Boo			
			23a. Part 1. Enter the disease, or comshock, or heart failure. List only	plications that one a	aused the death.	. Do not ente	r the mode	of dying,	such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		ank	in	50	,45		125	eas	2		et and Death
	Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):								0
	LAGIIIIIOI	<u>-</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
	ed sit	Examiner	cause, Enter Underlying Cause (Disease or injury											
	recute and al-trar	Еха	that initiated events resulting in death) Last	C. Due to	or as a conseque	ence of):								
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_	ificate ig phy as the	Med	IE EEMALE.					_				-1		
x 687	n certifica ending pl r use as t	an/I	IF FEMALE: 23b. Was decedent pregnant		come of pregnan Birth 2 🗌 Fetal		Ectopic p	regnancy				- 1	23d. Date of c	
Box	ed e	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of de		Other (sp	ecify)					Month	Day Year
o	requires that the death been signed by the attershould be detached for		Part II. Other significant conditions	ontributina to d	eath but not resu	ılting in the u	nderlying o	ause give	n in Part	1.	23e. Did t	obacco (use contribute	to the cause of death?
ď.	signe d be c	d by									1 🗆	Yes 2	™ 3 □	Probably 4 🗆 Unknown
ğ	requi	ete									24a, Was	an	24b. Were a	autopsy findings available
Records,	e law e has age 2	Completed									auto perfo	rmed2	death'	
	sician: The law i certificate has t lirector, page 2 s	BeC	25. Was case referred to medical	ī				26. Plac	ce of Dea	th <i>(Check</i>	1 Yes	2/C N	o 1 1 Y	es 254 NO
Žį.	ysician: is certifica director,	To B	examiner? 1 🗌 Yes 2 2 No	Hospital:	Inpatient 2 🗆 E	ER/Outpatien	nt 3 🗆 DO	Other	: 4 □ Nt	ursing Ho	me K Resi	dence 6	6 Other (Sp	ecify)
o	tending Physeath.		27. Manner of Death Natural 5 ☐ Pending	28a. Date (Mon	of injury th, Day, Year)	28b. Time of injury	2	Bc. Injury : work?			28d. Describe I	how injur	y occurred	
on	ttendir death. stor: Af y the fu	ifica	2 Accident Investigation	on l			М		res 2 🗆	-				
Division of Vital	lor Att after d Direct J in by	Certificate:	4 Homicide determined	, ∥28e. Place	of Injury - At hor ng, etc. (Specify)	ne, farm, stre	eet, factory	, office			28f. Location (City or Tov			Rural Route Number,
۵	Hospital or 24 hours afte Funeral Dir etely filled in		29a, Certifier 1 Certifying Phy	reician: To the h	sest of my knowle	dae death a	occurred at	the time	date and	nlace at	nd due to the c	ause(s) a	and manner as	stated.
	To the Hospital or Attending Physician: The law requires that the within 24 hours start death, within the A hours and that death. To the Functional pilector: After this certificate has been signed by the armotetely filled in by the foneral director, page 2 should be detached and the start of the foreign of the foreign of the start of the foreign of the start of the foreign of the start of th	ledical	(Check 2 Medical Examonly one) 3 Certifying Nu	niner: On the bas	sis of examination	and/or invest	tigation, in r	ny opinion	n, death o	ccurred at	the time, date	and place	e, and due to th	e cause(s) and manner stated
	To the	Σ	29b. Signature and title of certifier			,		License			T	29d. Da	ate signed (Mo	nth, Day, Year)
	150	ŀ	The state of the s				$ \mathcal{I} $	00	56	8	25-	50	1 pac	-31, 2012
•	100	1	30. Name and address of person who	completed caus	se of death (Item	23a) (Type, F	Print)	Sas	TP.	alo	-1575	10	-	
	JAN		William F. Bo	senh	eima	c, put	B	nen	-5/04	1500	mi	>		
	Sta Registr		31. Date filed (Month, Day, Year)	012 32.	egistrar's Signatu	ure	The state of	A.						
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DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 01

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

DHMH 17 Rev 1/2001

AMEND ITEM 7 PER FH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. WCHD/TF 11/8/2012 State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death A Physician/ Martha Jane HOSE Ctober 1:04 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Hagerstown Meritus Medical Center Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Hours 88_{Yrs} **Director** 217-12-1382 -99 1 M 2 X F April 10,1924 Maryland Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21740 USA 18012 Putter Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
1f Yes, Give Black, White, etc. should be filed within 72 hours after of and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. white Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) homemaker her own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert E. Bartles Anna Hamby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 14016 Rockdale Rd., Clear Spring, Maryland 21722 William Hose - son 27 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 \square Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) Broadfording Church Cem. 11/3/12 Hagerstown, Maryland 21. Signature of Funeral Service Licenae MINNICH FUNERAL HOME 22. Name and Address of Facility 415 E.Wilson Blvd., Hagerstown, Maryland 21740 Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Due to r as a consequence of): Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, reading to immedicause. Enter Underlying Due to (or as a consequence of, Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? detached for Month Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by guemia. Records, ummia, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of heavit 24a. Was an by Desten sive autopsy death?
1 Yes 2 No Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Division of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 1:00 PM Horton Betty Marle Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washina Hagerstown Julia Marror Iteal thrave If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex **Funeral Director** 1 □ M 2 🗙 F 82 177-24-5218 January Pennsylvania Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits at Director notified a Keedysville 1 Tes 2 No Washington County Maryland 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? P pe 23a (Completed by Funeral must k USA 21756 3017 Hawks Hill Lane filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ral", or iten Examiner r Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes X☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 🙀 No Specify Specify: White 3 Widowed 4 □ Divorced "natural", Year or Dates 27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. Homemaking Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file trent of Health and Mental trant: If item 27 is marked or jury or other traumatic eve ျှ Vores Smith Charles Myrt1e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 21756 Douglas Horton 3017 Hawks Hill Lane, Keedysville, Maryland 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Department of F Important: If ite any injury or ot cemetery, crematory or other place) Burial 2 Cremation Removal from State November 2, 2012 McConnelsburg, Donation 5 Other (Specify) Union Cemetery ature o Funeral Service L censee 22. Name and Address of Facility M-00849 Lochstampfor Funeral Home, Inc. 48 S. Church Street, Waynesboro Pennsylvania Dam death) Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death End Physician - sterce disease or condition resulting in death) Medical Examiner Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) requires that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ jo in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death be detached Unknown 9 Unknown Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mellitue 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an pertension or Attending Physician: The law page 2 perform certificate 1 Yes 2 No 1 Yes 2 No **Division of Vital** 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ ER/Outpatient 3 DOA 1 Inpatient 2 I this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar

		y 1 For 2012 State Registrar 1. Decedent's Name (First, Middle	se Type or P Amend #3 State of	···		ificate of D			Reg. N	0011	2 370	
Physicia Medi		Dorothy	Last) Heis	t				2. Date of Month		26, Yea	3. Time of De 11:25	
Exami		4a. Facility Name (if not institution, Homewood Ref	-	·	4	4b. City, Town, or Willian		of Death	4	c. County of De Washing	eath	
Funeral Director		170-22-2609	6. Sex 1 M 2 F 7	Age (In yrs. last birt		If Under 1 Year Months Days	If Under Hours		Day, Year)	. (Birthplace (State or F Country)	
faryland Ba-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Was	hington	Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No							10d. Inside City I	
with the N s 23a or 2 lust be no	Funeral Dir	10e. Street and Number 16505 Virgini	a Avenue						10g. C	itizen of What	Country?	
permit. Fage I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fire Z1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Marr 3 🏋 Widowed 4 □ Divorced	ied Armed Force 1 Yes 2 If Yes, Give				spanic Origin, Mexican Specify:	gin? (Specify Yes or N , Puerto Rican, etc.)	lo-	14. Race - American Indian, Black, White, etc. Specify: White		
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nd z shou lealth and m 27 is m her traum:		19a. Informant's Name/Relationsh Priscela Horne	ip (Type, Print)	scilla µghter) P	Mailing	Address (Street at Box 953 ,	nd Numbe She	r or Rural Route Num pherdstown	nber, City o	r Town, State, st Viro	Zip Code) Yinia 143	
Fage 1 a tment of H tant: If ite jury or oth		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other (S)			y, cremat	ion (Name of tory or other place		ember 3,20	1	-	or Town, State	
Depar Impor any in		100	Lechstam	~	48	S. Chur	ch S	uneral Hon	vnesb	nc. oro, Pe	17268 ennsylvani	
nysician/ Medical Examiner		23a Fart 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)						Cardiac or respiratory		er.	Approximate Interval Betwee Onset and Dea	
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within 24 hours after To the Funeral Dir completed filled in	Med	(Check 2 ☐ Medical Ex only one) 3 ☐ Certifying I	Physician: To the best aminer: On the basis of Nurse Practioner: To the	examination and/or	investiga	tion, in my opinion th occurred at the	, death occ time, date	curred at the time, date	and place	and due to the	e cause(s) and manne	
o Co		29b. Signature and title of certifier	w ~s			29c. License			1	te signed (Mor	20 ()	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2:42 Mary Ann Hershey 2013 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Meritus Medical Center Hagerstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1964 March 12, Hours Maryland 212-78-3786 Director 1 🗆 M 2 🕅 F 48 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location must be notified at Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral 23a U.S.A. 1380 Marshall Street 21740 items death 12. Was Decedent Ever in U.S. Armed Forcas?

1 Yes 2 No
1f Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Examiner Black White, etc. 1 X Never Married 2 Married ō Completed by 72 hours after Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic name. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Margaret Miller Hershev Harry 0scar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 North Potomac Street, Hagerstown, Md. 21740 Mary M. Hershey Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State Hagerstown, Maryland Hagerstown Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, A. hoel Md. 21740 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final ais Promician/ dos disease or condition resulting in death) Medical Due to (or as a conseq Examiner Eaguer trailly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🖼 No Month Year Pregnant at time of death Other (specify) signed by the and be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? I or Attending Physician: The after death.

Director: After this certificate! Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Medical Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury work? 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Opal Court Hazerstown, MD 21740 , MD Date filed (Mo) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death RIVER HesPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 🔀 M 2 🗆 F 216-38-9591 84 Director 04/09/1928 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director MD Kent Rock Hall 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 22012 Lovers Lane 21661 USA 12. Was Decedent Ever in U.S. Armed Forces? 195

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ıral", or iten I Examiner ı 14. Race - American Indian. 1951 Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. "natural", Specify: Black 3 Widowed 4 Divorced Completed 1955 Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Truck Driver Trucking Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willis Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22012 Lovers Lane Rock Hall, MD 21661 1 and 2 s of Health item 27 Helen Harris/Wife 20b. Place of Disposition (Name of cemetery, crematory or other p. Holy Trinity 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 Department of Important; If it any injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State AME 10/27/12 Rock Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) Church 22. Name and Address of Facility 21. Signature of Funeral Service Ocensee Dennie Smith Funeral Chestertown, MD 21620 855 High ST 23a. Part 1. Ent 1 the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ and melinoneng 30 min Medical Due to (or as a const uence of) Examiner 10 days OPD with. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-1 Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Intrapulmonary Hemorrhage Records, 1 \square Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown LUL of lung, showed adenoterinome D ASHD 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11.11. Ulum, MD. 02/3/3 10/23/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KINK. WUN 415 Washington Are., Chestertown, MD 21620 Me 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

P.O.

of Vital

Division

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0950 octobe 2012 HARRY CLIFFORD HARRIS, JR. Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Eastor Talbot Memorial Hospital at Easton If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 **X**M 2 □ F 81 Director 214-32-0299 11/19/1930 **MARYLAND** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location of Health and Mental Hygiene. item 23a or 28e-f show item 27 Is marked other then "natural", or items 23a or 28e-f show other traumatic event, the Medical Examiner must be notified et. Director 1 Yes 2 No TALBOT CORDOVA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 31299 DUKES BRIDGE RD. 21625 death \ 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. 1 ☐ Never Married 2 🕱 Married Š 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE If Yes Give 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) CONSTRUCTION CARPENTER Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harris VIOLA EMILY SARD Page 1 and 2 should be HARRY CLIFFORD HARRIS, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shr Department of Heatth an Important: If item 27 Is any injury or other trau 31299 DUKES BRIDGE RD. CORDOVA, MD 21625 STELLA M. HARRIS/WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRINGHILL CEMETERY 10/24/2012 EASTON, MD 21. Sign fore i Fundal I rvice License TEDLOWS GESTELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day ed by the a g 🗌 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed a page 2 should be det Completed by (itu) 1 Yes 2 No 3 Probably 4 Hunknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has performed? 1 ☐ Yes 2 ☐ No Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 🗌 Pending death. 1 ☐ Yes 2 ☐ No neral Director: Air Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier within 24 hor To the Fune completely fi 3 Certifying Nurse Practitioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 10 TLS WASHINGTON /ST 219 S. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2160 Puta 3TVA 0 2 MD. 31. Date filed (Month Day, Year) 0CT 23 32 Registrar's Signature State 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

DHMH 17 Rev 06-2011

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amend #5 Persign 6935 1/25/2013 JH

Amend Persign 6935 1/25/2013 JH

			1 - State OF IVIS	aryiand i Depa Cei	artment of F rtificate of D			ene 20	2	37020		
ı	Physicia	in/	1. Decedent's Name (First, Middle, Last) Elizabeth Iola Hance				2. Date of Death October	Pay 201	Xear	3. Time of Death 9:20 P M		
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or			4c. County of	f Death	9.20 1 W		
, 1	Francis		2001 Wash Hance Road 5. Social Security Number 6. Sex 7. Age 7.	e (In yrs. last birthday)	Port Rej	oublic If Under 24 Hrs.	8. Date of Birth	Calve		(D) 1		
	Funeral Director		218-14-3 099 1 □ M 2 🗓 F	90 Yrs.	Months Days	Hours Min.	(Month, Day, Y	ate of Birth 9. Birthplace (State or Country) y 22, 1922 Maryland				
	and show at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		buly 22,	1,22		Od. Inside City Limits		
	Maryla 28a-f otified	Director	Maryland Calvert	Port Repu	ıblic					1 Yes 2 X No		
	vith the 23a or st be n		10e. Street and Number 2001 Wash Hance Road		10f. Zip Code 20676		10	g. Citizen of W United		*		
	items	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?		Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-	14. Race	- America	n Indian,		
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: Injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give Year or Dates.	No	1 ☐ Yes 2 K No		nicari, etc.)	Specify:	, White, e white			
15-0	72 hou n "natu ledical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa	ition uring most of work	ing 10	6b. Kind of Bus	iness/Ind	ustry		
212	within giene, er tha		Elementary/Secondary (0-12) College (1-4 or 5	homen	O NOT use retired) naker			own hom	e			
and	ntal Hy ced oth	To Be	17. Father's Name (<i>First, Middl</i> e, Last) John Hutchins Gott				ne (First, Middle, Ma. Tola King	iden Surname)				
ary	and Me is mark	Ü	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	nd Number or Run	al Route Number, C					
e, Z	and 2 s Health s em 27 ther tra		Grifford H. Hance, Jr so 20a. Method of Disposition		Wash Hand							
Baltimore, Maryland 21215-0036	Page 1 nent of ant: If it		1	20b. Place of Dispo cemetery, cren Asbury Ce	natory or other place) !	Date 20/2012 Ba	oc. Location - 0				
Balt	permit. Departr Importa any inju		21. Signature of Euneral Service Licensee		Name and Address	s of Facility	Rausch Fi	ıneral	Home	. PA		
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ente	er the mode of dying	, such as cardiac	or respiratory arrest	1		Approximate Interval Between		
	Medical		Immediate Cause (Final disease or condition resulting in death))aliqua-	I he	plasm	of 75.	eaun	-	Onset and Death		
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	ed nsit	Examiner	of any leading to minimise at a cause. Enter Underlying Cause (Disease or injury	consequence of):								
	cate be executed physician and s the burial-transit		that initiated events resulting in death) Last C. Due to (or as a		en 810h			-				
09/	cate be physici s the bu	edical	d									
χ 29 20 20 20 20 20 20 20 20 20 20 20 20 20	n certific ending r use as								23d. Date of delivery			
. B0	he death y the ath sched for	Physician/M	in the past 12 months? 1 Yes 2 No 4 Pregnant at 9 Unknown 9 Unknown		Other (specify)			Month Day Year				
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours atter death. Within 24 hours atter death. The Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	è	Part II. Other significant conditions contributing to death but	at not resulting in the u	nderlyin g cause give	en in Part I.				cause of death?		
ord	w requi	Completed					24a. Was an	24b. We	ere autops	sy findings available		
Pec	sician: The law certificate has b lirector, page 2 s	J Com					autopsy performe		or to com ath? Yes 2	pletion of cause of		
/itai	sician: certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	nt 2 ER/Outpatien	Othor	ce of Death (Checi						
0	ng Phy fter this		27. Manner of Death 1	y 28b. Time of	28c. Injury work?	at	ome 5 🗹 Residenc 28d. Describe how					
Sion	Attendi r death. ctor: A by the fi	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	ry - At home, farm, stre	M 1 □ Y	res 2 □ No	28f. Location (Stree	at and Number	or Rumi E	Pourte Number		
2	ital or Jurs after ral Dire	-	building, etc.	(Specify)			City or Town, S	State)		Į.		
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated as the control of the cause o									o the caus	e(s) and manner stated.		
	To the comp	2	29b. Signature and title of certifier	best of my knowledge,	29c. License	number		I. Date signed (Month, Da	ay, Year)		
	,		D SUV MD	ath /ltore 02a\ /T == 5		0290				2012		
从	V4		30. Name and address of person who completed cause of de Dhire Name 13	0 Hosp	RD	Princ	e Fre	denic	h M	10 20678		
	Stat Registra	٠ :	31. Date filed (Month, Day, Year) 32. Registr	s Signature	bares							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death october Day 29 Physician/ 2012 4:10 Pm Ann Janet Holtzinger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** (Month, Day, Year) Months Days Hours 208-22-0318 **Director** 1 M 2 X F 84 Vre July 14, 1928 Pennsylvania Usual Residence of Deceden er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Maryland Frederick Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21703 United States of America 6720 Carpenter Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify. White 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health Care & Own Home Emergency Room Nurse & Homemaker 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William F. Brodbeck Katherene Heddinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6739B South Clifton Road, Frederick, Maryland 21703 Kim Whiteley / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 1, cemetery, crematory or other place) 1 🗋 Burial 2 🛣 Cremation 3 🗋 Removal from State Smithsbrug, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2012 Signature of Fune Keeney & Bastord P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ piratie disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Cars Sequentially list conditions, Examine Due to (or as a consequence oi): if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours all er death.

To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use or this build the funeral director. that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 ☐ Yes 2 🗙 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🙀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 6810 20 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State MOV 1 6 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G934 12/04/2012 Jh State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 20^{Year}2 24 Day 9:10 Hattie Ellen Hammons p^{M} Oct. Medical 4a. Facility Name (if not institution, give street and number)
Upper Chesapeake
Medical Center 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Bel Air Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral Min. Months Days (Month, Day, Year) 216-30-8691 Usual Residence of Decedent 450 COT Director 1 🗆 M 2 🗙 F July 26, 1917 WV 95 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director 1 Yes 2 No Baldwin MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2914 Baldwin Mill Road U.S.A. 21013 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene.

item 27 is marked other than '
other traumatic event, the Me Garment Elementary/Secondary (0-12) College (1-4 or 5+) Sewing Machine Operator Manufacturing JAMMONS, HAT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Flossie Ann Lewis Albert Harvey Crouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. 2914 Baldwin Mill Rd., Baldwin, MD 21013 Margie E. Billingslea/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 31 St: Paul Mirted Place)
Methodist Cemetery Oct. 2012 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Pylesville, MD Sig ture of Funeral Service 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. Stewartstown, PA 17363 Main St., 19 S. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ acl Hurle WRO disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 M0001555/64 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Aral or Attending Physician: The law requires una state death.

ris after death.

ral Director: After this certificate has been signe " - " maral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 Yes 2 No Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours a To the Funeral Completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifier ledicine 29c. License number 29d. Date signed (Month, Day, Year, cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp 21014 Nreama Uc 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		-	For State Of IVIS	aryiana / Depa <i>Cei</i>	artment of Fi tificate of D		ina ivientai H	ygiene Reg. No		0 1 0 2 0	
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Geraldine Elizabeth IRVING				2. Date of I	Death		3. Time of Death	
	Medic	al	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of	Octob		2012	2:37 p. M	
	Examin	er	18309 College Road			gerst			Washingto	n	
	Funeral		100 06 5050	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 2 Hours		Birth Day, Year)	9. Birthplace (State or Fore Country)		
	Director		Usual Residence of Decedent	Yrs.			Oct.	1, 19	29 Ma	ryland	
yland	-f sho	ctor	10a. State 10b. County	10c. City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🔀 No	
ле Маг	or 28a notifi	Dire	Maryland Washington 10e. Street and Number		Hagers	cown		10a Ci	tizen of What Cour		
with t	s 23a o	Funeral Director	18309 College Road		2	21740			USA		
death	r item		11. Marital Status 12. Was Decedent E-Armed Forces?	ver in U.S. 13.	Was Decedent of His f Yes, specify Cubar	spanic Orig n, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Americ Black, White,		
036	ral", o Exam	Completed by	1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 📆 If Yes, Give Year or Dates.	No .	1 ☐ Yes 2 🌠 No	Specify:		Specify: White			
5-0 2 hour	"natu edical	plet	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done d O NOT use retired)		of working	16b. k	Kind of Business/In	dustry	
:121 /ithin 7	r than	Com	Elementary/Secondary (0-12) College (1-4 or 5-		hospital						
Maryland 21215-0036 2 should be filed within 72 hours after	th and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Be c	17. Father's Name (First, Middle, Last)				's Name (First, Midd		,		
ryla uld be	J Ment narke natic e	To	Joseph Raymond Buchanan				ce Matilo				
	alth and 27 is r r traur		19a. Informant's Name/Relationship (Type, Print) Robert G. Irving - husband				or Rural Route Num ad, Hagers				
Baltimore, permit. Page 1 and	nt of Healtl :: If item 2 or other t		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗔 Removal from State	20b. Place of Dispo	osition (Name of matory or other place	e)	Date	20c. L	ocation - City or To	own, State	
timor t. Page 1	Department Important: It any injury or once,		4 Donation 5 Other (Specify)	Cedar Law	m Mem. Pa	ırk	11/3/12			, Maryland	
Ba bern	Depa Impo any ii once	И	21. Signature of Funeral Service Licenson				MINNICH Slvd., Hag			21740	
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause of each line.	the death. Do not ent	er the mode of dying	g, such a c	ardiac or respiratory	arrest,		Approximate Interval Between	
	ysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	consequence of):	lerabe	He	ay Lis	lase		Onset and Death	
	caminer		Due to (or as a	consequence of):	omia						
		iner	Se_uentially list conditions. if any, leading to immediate cause. Enter Underlying	consequence of);							
scuted	and -transi	xam	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):								
be ex	sician e buria	edical Examiner	d d								
68760 certificate be executed	been signed by the attending physician and should be detached for use as the burial-transit		IF FEMALE:								
Box 6	attendi for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3	Ectopic pregnanc Other (specify)	У		_ 1	23d. Date of deliv Month	Day Year	
6. B	y the a	hysid	1 Yes 2 No 9 Unknown 9 Unknown	time of death of							
ords, P.O.	gned b	by	Part II. Other significant conditions contributing to death by Otherse Fibrilla	-	underlying cause giv	en in Part I.	1		/	he cause of death?	
Records, The law requires	seen si	Completed	a de la la de la de	7 VO, 10	210		11			bably 4 Unknown	
Reco	has je 2	ldmc	O Valvular Heart Disease 3 Status Cerebro vascular autopsy prior to comple deart of the status of t								
	certificate irector, pag	Be C	25. Was case eferred to medical examiner?	· v wscocc			1 L Ye (Check only one)	s 2LM	lo 1 Yes	2 1 No	
r VII	this ce al dire	욘	1 ☐ Yes 2 ☐ NO 1 ☐ Inpatie	ent 2 ER/Outpatie		4 L Nu	rsing Home 5 Re			y)	
n o	ector: After this certific by the funeral director,	cate	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		work		28d. Describ	e how inju	ry occurred		
Division of Vital	after death Director: /	Certificate:	3 Suicide 6 Could not be	ry - At home, farm, str	eet, factory, office			Street ar	nd Number or Rura	l Route Number,	
Div	within 24 hours after To the Funeral Direc comple te ly filled in b										
e Hosp	ithin 24 hours a • the Funeral D • impletely filled i	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of response only one) 3 Certifying Nurse Practitioner: To the	amination and/or inves	tigation, in my opinio	n, death oc	curred at the time, dat	e and place	e, and due to the ca	ause(s) and manner stated.	
To th	To the	2	29b. Signature and title of certifier		29c, License		,		ate signed (Month,		
			- Hustphlore	MD	100/	5 78			11/12		
JW	-3		30. Name and address of person who completed cause of de FRANCISCO L. ADDRAD	eath (Item 23a) (Type, I	MILL	57.	HAGER.	57001	U MD 2	1740	
×	Stat Registra		31. Date filed (Month, Day, Year) 32. Segistra	r's Signature	laces		•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:00PM 28 2012 Gerald Wilbur Ingram Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JuliaMarion Hagerstown Washington It earth care If Under 1 Year If Under 24 Hrs . Social Security Numbe 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 215-42-3619 Director 1 🖾 M 2 🗆 F 67 July 1, 1945 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 K Yes 2 No Maryland | Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō ral", or items 23a o Examiner must be Funeral 21740 423 Wyoming Avenue U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No ò 1 Never Married 2 Married 1 Yes 'natural", or Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Custodial Janitor and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Arnold James Ingram Lillie May Jamison and 2 should be Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once, 423 Wyoming Avenue, Hagerstown, Maryland 21740 Mary E. Ingram / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery 11/03/2012 Hagerstown, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only the cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Stage. disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and use as the burialiding physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ jo in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 Pregnant
9 Unknown Month Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by Stenosis, Diabetes Mellitus, Myocardial Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Infarct cate has ; page 2 : autopsy Yes 2 N this certificate 25. Was case referred to medica 26. Place of Death (Check only one) Division of Vital Be Other: 1 Yes 2 X No မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work?
1 Yes 2 No 5 Pending 124 hours after death. e Funeral Director: Aft bletely filled in by the ful Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f (Check only one 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year)

JW-3
State

Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barbara Nader Blucher

R125360

10

RNP-333 Mill Street, Hagerstown, MD 21740

12s

Name and address of person who completed cause of death (Item 23a)
 Ana Rubio M.D., Ph. D. Assistant Medical Examiner

900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State gistrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ avanhe Aldean Richard Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Funkstown Washington 6 North Antietam Street If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🖳 M 2 🗆 F Months Year 19<u>48</u> July 18 Marvland 216-54-8722 64 **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 ¥ Yes 2 ☐ No Maryland Washington Funkstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 6 North Antietam Street 21734 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. à 1 X Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 !
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event " (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Painting Contractor 12 Painter Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Kenneth Jones Betty Lee Wolfenberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9-C Hopewell Road, Williamsport, Maryland 21795 Gary L. Jones Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Hagerstown Crematory: 11-02-12 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, hoel 21740 Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CIFFHO disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transit signed by the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Dulmonat this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed's 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, Be Hospital: Other: 2 DANO ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director, After 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie o the Hc. within 2/ To th (Check only one) 29b. Signature and title of wembe Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Northeth

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CLARA ANN JUBB 0111 October 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Easton Easton Talbot Memorial Hospital at Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) Country) 217-76-6370 Director 86 1 □ M 2 🕅 F APRIL 13,1926 WEST VIRGINIA Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD TALBOT EASTON 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25756 ST. MICHAELS ROAD 21601 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🐼 No Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🕅 No Specify: WHITE 3 X Widowed 4 Divorced Specify. 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည STERLING VAN PELT GERTIE HOGAU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25756 ST. MICHAELS ROAD, EASTON, MD NANCY L. BRODIE, DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🗋 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/20/2012 ELDORADO CEMETERY ELDORADO, MARYLAND 21. Signature of Funeral Service Lic FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P 200 SOUTH HARRISON STREET, EASTON, MD 21601 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION Physician PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner GASTRO SAITESTINAL HEMORRAGE HOURS Sequentially list conditions, Due to (or as a consequence of) ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Day 1 Yes 2 L 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ CARDIOMYOPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performed? Yes 2 W Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 욘 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No 1 Natural 5 Pending within 24 hours after death To the Funeral Director: A completely filled in by the f 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Continuing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number Thamer OCTOBER 14 2012 D0066441 TUS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21601 Street , Easton Kolli, Ramesh 2195 Warnington 2 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 1 7 2012 Registrar

State of Maryland / Department of Health and Mental Hygiene U = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Muna Fatu Kamara October 25, 2012 6:45 p. M Medical 4a. Facility Name (if not institution, give street and number) Apt. 5 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 6815 Riverdale Road; Building E Riverdale Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1985 Months Days Hours 216-65-4197 Sierra Leone, West Africa **Director** 1 □ M 2 🗶 F 27 September 14, Usual Residence of Decedent 28a-f show 10d. Inside City Limits Oa. State 10c. City, Town or Location notified at Director 1X Yes 2 No Riverdale Maryland | Prince Georges 10f. Zip Code 10e. Street and Number ò 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be i Funeral 20737 United States 6815 Riverdale Road; Building E; Apt. 5 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 hours after Black If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working l Hygiene. other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the **Medicals** Nurse's Aide 12th grade and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ Adama Cecilia Kamara Sinneh Kamara traumatic permit. Page 1 and 2 sh.
Department of Health and.
Important: If item 27 is m. any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 Syria Court; Fort Washington, Maryland 20744 Adama Cecilia Kamara (Mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov.9 1 X Burial 2 Cremation 3 Removal from State Sierra Leone, West Nakeni - Fadugu Cemetery 4 ☐ Donation 5 ☐ Other (Specify) <u>Africa</u> 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 C0333 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ neopl disease or condition resulting in death) malianan Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to infinishing cause. Enter Underlying Examine Due to for abla consequence of: and I-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 thek ast IF FEMALE nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No for Dav the Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No has 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes Other: 2 **X** No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of nours after death. neral Director: After th filled in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Accident Investigation 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled To the Hospital Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗹 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) 3500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1801 McCormick Drive; Suite 180 1801 McCormick Dr Largo, Maryland State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 1 2012 Physician/ Paul David Koontz 1:11Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Williamsport Washington Homewood at Williamsport If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 219-12-1534 90 1 M 2 □ F Director March 19,1922 Pennsylvania should be filed within 72 nows are and Mental Hygiene.

7 is marked other than "natural", or items 23a or 28a-f show arked other than "natural", or items 25a or 28a-f show arked other than "Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Maryland Washington Williamsport 1 Yes 2X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21795 16505 Virginia Ave. A110 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Door Mfg. Co. Foreman treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence H. Koontz Cornelia Hykes 1 and 2 should be of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14726 Fairview Church Rd. Clear Spring, MD 21722 Ronald Koontz-son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pege 1 and Department of I important: If its eny injury or of Broadfording Church 1 X Burial 2 Cremation 3 Removal from State 11-5-2012 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility Touglas A. Fiery Funeral Home 21. Signature of Funeral Service Licens 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications acaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on, each line. shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death) NUK Pnysician Medical Due le (or as a consequence of): *Examiner Sequentially list conditions, if any, leading to immediate Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director. After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Certificate: work? 1 Yes 2 No 5 - Pending Natural 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Framiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Gertifying Nurse Plactitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 06-2011

no completed cause of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ Month Nov 12:35 P M Audrey Violet KAGLE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death <u> Homewood Retirement Village</u> Washington Williamsport Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Hours Min. Director 220-22-4175
Usual Residence of Dec 1 □ M 2 🖾 F 86 Yrs. 13 1926 Maryland Sept. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10h Count 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2xx No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12900 Mattley Drive 21742 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🜠 No Specify: If Yes, Give White Completed Specify: 3 XX Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Telephone Operator Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental F is marked or ည Virgil Bowling Kathryn Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Rick Kagle - Son American Way, Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 11/5/2012 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on the or line. Approximate nterval Betwee Immediate Cause (Final disease or condition Priysician/ Medical resulting in death) Examiner DIACRAM Sequentially list conditions, if any, leading to immediate cause. Emer underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy 4Porter 1 Yes 2 No 25. Was ca eferred to Be medical 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu ☐ Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on title of certifier 29b. Signatu 12

State Registrar (Item 23a) (Type, Print)

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 24, 201^{Year} JOHN I.F. KNUD-HANSEN, MD 4:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 28230 HARLEIGH LANE OXFORD TALBOT Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) Days Hours Country) Director 181-20-0693 1 X M 2 🗆 F 93 Yrs. MARCH 3, 1919 VIRGIN ISLANDS Usual Residence of Decedent 27 is merked other than "naturel", or items 23a or 28e-f show treumetic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo MD TALBOT OXFORD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21654 USA 28230 HARLEIGH LANE 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify 3 Widowed 4 Divorced WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nould be filed within 72 nd Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) SURGEON MEDICINE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ THERESE RUBY HASSELL KNUD KNUD-HANSEN 19a. Informant's Name/Relationship (Type, Print) 19b. MPlig Oxldr BOXreel 60Num FASEON guteND mber 2dt 60 dbwn, State, Zip Code) permit. Page 1 end 2 st Department of Health a Importent: If Item 27 is any Injury or other tree MERRILYN KNUD-HANSEN, WIFE 28230 HARLEIGH LANE, OXFORD, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State STEVENSVILLE, MD 10/25/2012 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 21. Signature of Funeral Service I 2 Name and Address of Facility ELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P 00 SOUTH HARRISON STREET, EASTON, MD 21601 Fart 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus Interval Between Onset and Death Immediate Cause (Final Physician/ heimers disease or condition resulting in death) ins Medical Due to (or as a consequence of) Examiner Sequentially list conditions. fary leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Que to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an cate has t page 2 s autopsy performed? Yes 2 2 prior to completion of cause of death? or Attending Physician: The 1 Tyes director, **Division of Vital** 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 ☑ No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this d In by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be ☐ Suicide To the Hospital or Att within 24 hours after do To the Funerel Direct completely filled in by 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 415 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+VA

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State Registrar

285

68760

P.O.

503 CYNWOOD DRIVE, EASTON, MD

21601

EGLSEDEŔ,

III, MD

32. Registrar's Signature

LUDWIG J.

31. Date filed (Month, Day, Year) OCI 2 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER BARBARA TODD KINGSTON 6:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TALBOT HEARTFIELDS AT EASTON EASTON Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 092-24-5167 90 **Director** 1 □ M 2 🕅 F 11/14/1921 NEW YORK ifiled within 72 hours area. — ital Hygiene.
ed other than "natural", or items 23a or 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director EASTON TALBOT 1 X Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21601 700 PORT STREET USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) TEACHER NURSERY SCHOOL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental ! is marked o ၉ HAZEL A. VANNESS GEORGE E. TODD 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 418 AUGUST STREET, EASTON, MD KIRSTIE A. KINGSTON, DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION: 10/17/2012 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signative of Fundal Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON STREET, EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) 12 Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the attending physician and ched for use as the burial-transit Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 70 Day 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 Ano 3 Probably 4 Unknown Completed 24b. Were autoosy findings available 24a. Was an prior to completion of cause of death? performed? 1 🗌 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specif ASST.LIVING 1 🔲 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1. Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

123 3

Registrar

JORGE H. ABREGO, MD 31. Date filed (Month, Day, Year) OCT 1 8 2012 State

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

598 CYNWOOD DRIVE, SUITE 104, EASTON, MD

1136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ 08:00 M Joseph Kilmon Oct. 18^{ay} George 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death

Talbot **Examiner** 4b. City. Town, or Location of Death 8285 Gannon Circle Easton 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign ^{Yea}r) 1937 Days 6/12/ 218-34-7998 **Director** 1 🗶 M 2 🗆 F 75 MD. Usual Residence of Decedent 28a-f show 10a. State items 23a or 28a-f shoner must be notified at 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MD. Talbot Easton 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' 8285 Gannon Circle 21601 U.S.A. al Hygiene. d other than "natural", or items event, the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ Noarmy If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2X Married should be filed within 72 hours after and Mental Hygiene. Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Printing Plant Manager Be 18. Mother's Name (First, Middle, Maiden Surname)

Mary Margaret Strohmer 17. Father's Name (First, Middle, Last, permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev မ Levi Scott Kilmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 8285 Gannon Circle, Easton, MD. 21601 Betty Sue Kilmon/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Woodlawn Mem Park 10-23-12 Easton, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Hurley dres of Strowski Funeral Home P 21663 5.0 Joseph M. Ostnowski P.O. Box 518 St. Michaels, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ PROSTATE CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): ohysician ar the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 phy 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy perform death? 1 ☐ Yes 2 ☐ No 1 Yes 2 25. Was case referred to medical director 26. Place of Death (Check only one) examiner? ျ 2 No Other: 1 🔲 Yes 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination allows investigation, it may opinion, accurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the I

comple the only one) 29b. Signature and title of certifier 0 D39887

125 1+VA

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person

OCT 2 4 2012

SMITH, DAVID 8221

TEAL DRIVE, EASTON, MD 21601 Registrar's Signature

prieted cause of death (Item 23a) (Type, Print)

10-22-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gayle 0412 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death County of Death university of Maryland Medical Center Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours 221-54-6555 05/23/1958 54 Director Virginia 1 M 2 X F Usual Residence of Deced show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 ehren injury or other traumatic event 10a, State 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🖵 No Marvland Calvert St. Leonard 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6021 Bayview Road 20685 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. <u>\$</u> 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DONA use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Andrew Robertson Anne Sutton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 6021 Bayview Rd. St. Leonard, MD 20685 Larry W. Kem - spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 10/23 \$ 2012 1 Burial 2 La Cremation 3 Removal from State Metropolitan Funeral Service Alexandria Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Eunoral Service Licensee once 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death o litis disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): sician a e burial-Physician/Medical Box 68760 attending physical for use as the b IF FEMALE: outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months? Pregnant at time of death Month ed by the a detached i 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End-stage been sig should t 1 Yes 2 No 3 Probably 4 Unknown ", After this certificate has bue funeral director, page 2 sh 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ဂ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending after death.

Director; Af Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a **To the Funeral D** Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely The deficient examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 20/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dru) 10 nattheu ssauer 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Physician/ $4:00P^{M}$ 10 2012 Constantine G. Koste Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Talbot 100 Pleasant Street Oxford 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Davs Hours (Month, Day, Year) Country) 216-38-7682 Director 1 XM 2 □ F 71 -20 - 1941Usual Residence of Decedent MD10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10a State Director 1 X Yes 2 No Talbot MD Oxford 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Funeral USA 100 Pleasant 21654 Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 should be filed within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify "natural", 3 Widowed 4 Divorced Completed White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Mental Hygiene. Food Broker Food Service 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie Chapis George Koste item 27 is me 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 Pleasant Street, MD 21654 Carol Koste/wife Oxford, item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 🗌 Burial 2 XCremation 3 🗀 Removal from State 9 Department of Important: If any injury or Mid Shore Center 10-27-2012 4 Donation 5 Other (Specify) Cambridge, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 308 High Street Cambridge, MD 21613 FHNewcomb&Collins 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Annroximate Interval Between Onset and Death Immediate Cause (Final Addes WetA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner cuentielly list-conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Azlezu 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CORENAR Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s autopsy performed? 2 🗌 No Yes 2 Yes certificate 26. Place of Death (Check only one) To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be examiner? Hospital Other: 4 Nursing Home 5 Amesidence 6 Other (Specify) 1 Tyes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA ည After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 27. Manner Death 28c. Injury at work? 1 \(\text{Yes} \) 2 \(\text{D} \) No iniurv 1 Natural 5 Pending after death. Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar R.

30. Name and address of person who completed cause of de

Bruce Helmly

OCT 26 201

31. Date filed (Month, Day, Year)

522

Idl

Registrar's Signatu

th (Item 23a) (Type, Print)

ewild

D0053Z36

Ave Easton, MD 21601

October 26,

2017

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 10e, 19b, per fh, g933 11-16-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ANN 11 46 AM KARIM 2017 November Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, Examiner University of Maryland Medical Center Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours 214-64-3689 Director 1 □ M 2 🂢 F 56 2/26/1956 WASHINGTON, DC Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events. 10a. State 10c. City, Town or Location Director MD HAGERSTOWN WASHINGTON 1 🐼 Yes 2 🗌 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11 N. Baltimore ST. Apt 108 21742 Completed by Funeral 17928 CARDEN LANE APT. 33 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 Å No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 XMarried WHITE 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working COMPUTER SYSTEMS OPERATOR Elementary/Secondary (0-12) College (1-4 or 5+) HOTEL Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HUNTER DANIEL JOHNSON ပ MARIANNE BELT 19b. Mai Address St. Frank Number Strata Apute 108 r, City or Town, State, Zip Code) 17928 CARDEN LANE APT. 33, HAGERSTOWN, MD 21742 21740 19a. Informant's Name/Relationship (Type, Print) MOHAMED KARIM/SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition NOV. 10. 1 Burial 2 Cremation 3 Removal from State SHEPHERDSTOWN, WV ELMWOOD CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, Robert 327 W. KING ST. MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intestinal Physician/ brastro disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Stage disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hepatitis Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown signed by the atter Day 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed?
Yes 2 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 N Inpatient 2 ER/Outpatient 3 DOA မ After this eral Director: After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier John Sin MD P25726 November 2012 Resident 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Baltimore 21201 22 Greene 31. Date filed (Month, Da ay, Year) 1 6 2012 State

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month **Physician** 30, 2012 9:01 Long, October 0 Norman Lansdale /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 15520 Thompson Road Silver Spring 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1₺ M 2□ F 218-26-5606 Oct. 1930 MD 82 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantina must be mailled at 1 Yes 2 No Director MD Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20905 USA 15520 Thompson Road Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: 1950-54 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Public Service Metropolitan Policeman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Cleopatra Bowles NOrman Lansdale Long, Sr. ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 15520 Thompson Road, Silver Spring, MD 20905 Rosemarie Long/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Nov. 7, 1 ■ Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 2012 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servix Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Kihardt Lates 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final **Physician** yrs Gall Bladder Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): g physician and as the burnessit Hospital or Attending Physician: The law requires that the death certificate be executed Az hours after death.

Authorial Director: After this certificate has been signed by the attending physician and sely filled in by the funeral director, page 2 should be detached for use as the burnerage. Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ∐Yes 2 □ No 1 ☐ Yes 2 ☒ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely f (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signal Ge and title of certifier 29c. License number October 30, 2012 D21910 5+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter B. Sherer, MD 3921 Ferrara Drive, Wheaton, MD 20906 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 01 2012 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Raymond Harold Lindsay .Tr. Medical November 10:54 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 552 W. Church st. Washington Hagerstown Social Security Number **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Hours Min. **Director** 219-36-3439 1 X M 2 D F 73 02/20/1939 Maryland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 552 W. Church St 21740 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. þ 1 Never Married 2 K Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Sandblaster/Finisher Industrial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Harold Lindsay, Sr. Vivian Irene Lindsay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dee J. Lindsay / Wife 552 W. Church St. Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 11/05/2012 | Hagerstown, Maryland 21. Signature of Juneral Service Live See 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or compli s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one Interval Between Onset and Death Immediate Cause (Final Physician/ oronal disease or condition resulting in death) me Yellt Medical Due to (or as a conseque Examiner lear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician by Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 month Month Day Pregnant at time of death 5 Other (specify) Yes 1 Urknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 2 No 3 Probably 4 Unknown letely filled in by the funeral director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law this certificate has autopsy death? perforn 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No P 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Sesidence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be within 24 hours after death To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Monti

of death (Item 23a) (Type, Print)

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			For State	State of Mary	rland / Depa	artment of I	Health and	Mental Hyg	giene 2 () 2 3	7039
_			Registrar 1. Decedent's Name (First, Middle, Las		Cer	tificate of i	Death	2. Date of Dea	Reg. No.	2 7	me of Death
	Physicia	n/	1. Decedent's Name (1 #31, 1/modie, Eds	Terri Lynn	T:11v			Novembe	Day	2012 161	
	Medic Examin		4a. Facility Name (if not institution, give		шттту	4b. City. Town, o	or Location of Deat			y of Death	
	Examin	er	21 Norman Allen S			E1kto			Ce	ci1	
	Funeral		5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs		h	9. Birthplace (S Country)	tate or Foreign
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	or 28	ä	Maryland Cecil 10e. Street and Number		E1kton_	10f. Zip Code			10g. Citizen of	What Country?	
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	eath tems er mu	Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. V		Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No-	14. Ra	ce - American Indi	
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b	iled v Il Hyg I othe vent,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Surnar	ne)	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Medical Examiner must be notified at once.	오	Paul Jackson Lil	Ly			Marga	ret Alexa	ander		
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Division of Vital Records,	er de	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Hornicide determined	28e. Place of Injury - building, etc. (S		eet, factory, office		28f. Location (S City or Tov		ber or Rural Route	Number,
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	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 124 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Medical	(Check 2 Medical Exam	sician: To the best of my ner: On the basis of exam	ination and/or inves	tigation, in my opii	nion, death occurred	d at the time, date a	and place, and o	due to the cause(s) a	and manner stated.
	To the within 2 To the comple	Ž	only one) 3 Certifying Nur. 29b. Signature and title of certifier	se Practitioner: To the be	est of my knowledge		t the time, date and se number	prace, and due to		manner as stated. ned (Month, Day, Ye	ear)
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

/	 State Registrar Decedent's Name (First, Middle, 	Last)	<u> </u>	Cer	tificate of L	Death		2. Date of Dea	Reg. No. 2	112	3704	
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cto	10a. State 10b. County	1	10c. City								10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
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9	Lorenza Harri	ls				Luc	y Gr	iffith				
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AMEND #25, PER ME G933 11/30/12 TRT State of Maryland / Department of Health and Mental Hygiene 2 0 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year/ Day Month Physician/ 7/6 M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Laurel Regional Hospital Laure] Prince Georges If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours Months 216-30-4610 Director 1 □ M 2 🏻 F 2/21/1933 MD 79 Usual Residence of Deced or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 XYes 2 No Beltsville MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 must be 23a Funeral 5608 Odell Road 20705 USA death with items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ıral", or iten I Examiner n 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black "natural", 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cook-Alcoholic Annoymous Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Ollie Moore, Sr. Addie Wallace 19a. Informant's Name/Relationship (Type, Print)
Joan L. Clark/sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5608 Odell Road, Beltsville, MD 20705 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Mt. Zion UMC Cem. 11/10/2012 Laurel, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Snowden Funeral Home . Signature q neral Service Licens 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Septic Shock disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Acute Respiratory Failure Sequentially list conditions Examiner cause. Enter Underlying CERTIFICATION APPROVED BY MEDICAL EXAMINER To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or injury that initiated events Hyperkalemia and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical <u>Acute Kidney injury</u> Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Year Day Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed hours after death. Ineral Director: After this certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completely filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \) Other (Specify) 1 Minpatient 2 ER/Outpatient 3 DCA မှ 27. Manner of Death 28c. Injury at work? 1 □ Yes 2 □ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending Investigation 6 Could not be 2 Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 11/1/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Rd, Zorayda Lee-Llacer Laurel, MD 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Julia Avent Murchison 10-16-20129:09 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town or Location of Death 4c. County of Death Prince George's 1305 Kings Valley Drive Mitchellville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 577-52-7852 Director 75 1 □ M 2X F 12-15-1936 DC er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Mitchellville 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1305 Kings Valley Drive 20721 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within 72. In and Mental Hygiene.
7 is marked other than "r. (Specify only highest grade completed) US Department of Elementary/Secondary (0-12) College (1-4 or 5+) Agriculture Personnel Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse Avent Marion Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a If item 27 is Larry Murchison /Son 2098 Tanglewood Drive, Waldorf MD 20601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 permit. Page 1 Department of Important: If ii any injury or o cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery 10/25/2012 Washington, DC . Sign turi, of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home 4217 Ninth St. NW Washington, DC 20011 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for all a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and r use as the burial-trans Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ 23d. Date of delivery for in the past 12 months?
1 ☐ Yes 2 ☒ No Year Dav Pregnant at time of death 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed d be der 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performe 1 ☐ Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 🔀 No Other: 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 X Residence 6 Other (Specify) completely filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 1 X Natural (Month, Day, Year) 5 Pending injury after death.

Director: Aft ☐ Accident ☐ Suicide 1 🗆 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 2 Hannew 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) McCormick Dr Suite 180, Largo MD

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

1801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November T Physician/ 2012 9:35 Glenna Victoria May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington 1705 Mt. Aetna Rd. Hagerstown 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 7, 1926 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 220-18-0939 Director 1 □ M 2 🛚 F 86 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Maryland Washington Hagerstown 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1705 Mt. Aetna Rd. U.S.A. 21742 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Ves Give Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James T. Haney Florence E. Swope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1705 Mt. Aetna Rd. Hagerstown, MD 21742 Vickie Schleigh-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory 11-3-2012 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2

Cremation 3

Removal from State Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home Supremented Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ Renal Stage disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Metustute conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Corunay Ouler
Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed arkey Dise as the burial-trar that initiated events resulting in death) Last the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death signed by the a sid be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signate and the funeral director, page 2 should be a should be 24b. Were autopsy findings available Hypertension 24a. Was an prior to completion of cause of death? performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Home huspice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury Accident Investigation 6 🗌 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12/2012 D0071082

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month

Susana M. Goham

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) OCTOBER Physician/ 922 pM 2012 Ken McCullough Lanny Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown Washington Meritus Medical Center 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Funeral Min Hours 69 180-34-9193 Director 1 🖾 M 2 🗆 F 11/21/1942 Pennsylvania Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County must be notified at Director 1 X Yes 2 □ No Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 0 Funeral items 23a U.S.A. 49 Sunbrook Lane 21742 death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Medical Examiner Black, White, etc Armed Forces?

1 Yes 2 No ō à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates Specify "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Teacher Education other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be filed and Mental H မ Eleanor Gayle Barton Kenneth McCullough injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 s
Department of Health a.
Important: If item 27 is
any injury or 49 Sunbrook Lane, Hagerstown, MD 21742 Barbara McCullough/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 10/31/2012 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee

S. Mark

Sur 1601 Pennsylvania Ave. Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complic. ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one Interval Between set and Death Immediate Cause (Final €nysician/ mennondo disease or condition Medical resulting in death) Due to or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin eren rovas Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) attending physician ledical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 the use as 1 Physician/M IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 052723 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JW-6 pallourt, Hagystown, MO State Registrar

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21215-0036 within 72 hours after	ral", c Exam	ed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		46	☐ Yes 2	X No	Specify:				Specify:	White	
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e, P	Department or results are received by years. The many injury or other traumatic event, the Medical Examiner must be notified at once.	-	Bonnie B. McAfee 20a. Method of Disposition	- Wife	20b. Pli	1633 ace of Dispo			Plac	ce, Ap			Iagerst Location - City		
Baltimore, permit. Page 1 and	nt: If i		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		, ce	metery, cren	natory or ot	her place					erstown		
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ion tendir	the fu	Certificate:	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be				М	1 🗆	Yes 2 🗆	_					
Division of Vital Records, alor Attending Physician: The law requires after cleath.	Direct 1 in by	Cert	4 Homicide determined	28e. Place of In	jury - At hor c. (Specify)		eet, factory	office		28	3f. Location (City or To		and Number or te)	Rural Route N	umber,
Division of Vital Records, P.O. Box Hospital or Attending Physician: The law requires that the death 24 hours after death.	To the Funeral Director. After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Phys												
To the Ho	the Fu	Med	(Check 2 Medical Exami only one) 3 Certifying Nurs				death occu	irred at th	ne time, dat			the cau	se(s) and manne	er as stated.	
P P	200		29b. Signature and title of certifier	16=0			29c.	License 2	number	7		29d. D	Date signed (Mo	onth, Day, Year)
			30. Name and address of person who c	completed cause of	death (Item	23a) (Tivne II	Print)				11		1/2	A .	
JW-	15.4	1	ABOUL WAH	EED WD	_ i2	-821 -	-OA	1<1+	11(/	AVE.	HAG	ÉR	slown	, my	21742
	Stat Registra		31. Date filed (Month) Pey (Year)	32. Registr	rar's Signati		Sold and								

			For State of Ma		epartment of H Certificate of D			ene 201	2 37046	
ı	Physicia	ın/	1. Decedent's Name (First, Middle, Last)	-			2. Date of Death Month	Day Yea	3. Time of Death 2 1:20P M	
	Medic Examin	al	Charles Edward Murray 4a. Facility Name (if not institution, give street and number)	/	4b. City, Town, or	Location of Death	October	4c. County of De	eath	
أمس			11523 Holly Road	Marine Land high I	Ridgel	y If Under 24 Hrs.	O Data of Birdh	Carol		
	Funeral Director		5. Social Security Number 214-30-8983	(In yrs. last birthd 81 Yr	Months Days	Hours Min.	8. Date of Birth June 28	^Y 1931	Birthplace (State or Foreign Country) Maryland	
	nd thow at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits	
	Maryla 28a-f s otified	irect	Maryland Caroline	Ridgel	Ly				1 ☐ Yes 2 🛣 No	
	ith the 23a or st be n	Funeral Director	10e. Street and Number 11523 Holly Road		10f. Zip Code 216	60	11	g. Citizen of What Country?		
	death w items ? ier mus		11. Marital Status 12. Was Decedent E	ver in U.S.	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe	cify Yes or No- Rican, etc.)		nerican Indian,	
330	e filed within 72 hours after death with the Maryland that Hyglene. ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 Never Married 2 Married 3 Never Married 1 Never Married 2 Married 3 Never Married 4	Specify: B						
9500-612	2 hours "natur edical I	Completed	15. Decedent's Education (Specify only highest grade completed)	(0	ecedent's Usual Occupa Give kind of work done d		ng	16b. Kind of Busines	ss Industry	
LZ.L7	within 7 giene.		Elementary/Seconday (0-12) College (1-4 or 5 high sch ged 2	+)	e. DO NOT use retired) oholsterer		τ	upholster	y industry	
gue	e filed ntal Hyg ed oth event,	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	,			
Maryland	and Mer s mark maric		James Raymond Murray 19a. Informant's Name/Relationship (Type, Print)	19b. N	Mailing Address (Street a	and Number or Rura	l Route Number, (City or Town, State,	Zip Code)	
Ž.	and 2 st featth a m 27 is her tra		Betty Y. Murray/ wife		523 Holly R					
more	Page 1 sent of H		20a. Method of Disposition 1 ↑ Burial 2 ○ Cremation 3 ○ Removal from State 4 ○ Donation 5 ○ Other (Specify)	cemetery	Disposition (Name of crematory or other place Shore Vet	e) i		20c. Location - City Hurlock,	or lown, State Maryland	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilt and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 a or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		21. Signature of Funeral Service Licensee		22. Name and Addres	s of Facility DO	Box 160	; Greensberal Home	oro, MD , PA; 21639	
ì			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not	enter the mode of dying	g, such as cardiac o			Approximate Interval Between	
4	Medical		Immediate Cause (Final disease or condition resulting in death)	a consequence of):	ny Ca	nev			Onset and Death	
	Examiner	_	Sequentially list conditions, b.	oonsequonee on	0				0	
	ed sit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or liniury	i consequence on						
	cate be executed physician and the burial-transit	al Exa	that initiated events resulting in death) Last C. Due to (or as a	a consequence of)	:					
% %	ficate b g physi as the b	Medical	d				-			
. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome to the pregnant at the pregnant	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	y		23d. Date of Month	delivery Day Year	
Js, P.O.	luires that the signed by all de detact	by	Part II. Other significant conditions contributing to death b	ut not resulting in	the underlying cause giv	ven in Part I.			to the cause of death?	
Vital Records,	The law rec cate has bee page 2 sho	Completed					24a. Was ar autops perform 1 \sum Yes 2	y prior death	autopsy findings available to completion of cause of ?? Yes 2 \(\sumbole \) No	
/Ital	s certifi	To Be	25. Was case referred to medical examiner? 1	ent 2 🗆 ER/Qutp	Othe	er:		ence 6 □ Other (Sp	necify)	
n of	nding Phy th. : After this e funeral c		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injun (Month, Day)	ry 28b. Tin	ne of 28c. Injury	/ at		w injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division of	il or Atter after des Director d in by the	Certificate:	2 Cuiside 6 Could not be	rry - At home, farm c. (Specify)	n, street, factory, office		28f. Location (Str City or Town		Rural Route Number,	
_	ne Hospita n 24 hours ne Funeral	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of only one) 3 Certifying Nurse Practioner: To the	xamination and/or i	nvestigation, in my opinio	on, death occurred a	the time, date and	d place, and due to tl	ne cause(s) and manner stated.	
_	To the virthing of the complete of the complet		29b. Signature and title of certifier	21	29c. License	number	2	9d. Date signed (Mo	onth, Day, Year)	
	ł i		30. Name and address of person who completed cause of de	eath (Item 23a) (Ty	pe, Print)	41636		10 2	4/2012	
	Sta	10	31. Date filed (Month, Day Year) 2.8 2012 32! Recorre	50C ar's Signature	I Idlewi	ld Ane	East	on, mi	21601	
	Sta Registr		OCT 28 2012	mora de	-					

Glen Lamor Mor	ris	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2012 3704
Physicia Medical Exami	an/ ner	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 100 Railroad Avenue Elkton Cecil
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Country) 9. DE
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
Maryland 28a-f shnw d at once.	tor	MD Cecil Perryville 100 Citizen of What Country
eath with the Maryland items 23a nr 28a-f shn ust be notified at once.	al Director	501 Avon Street 21903 USA
고 급립	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 2 Married 2 No If Yes 2 No 3 Widowed 4 Divorced If Yes, Specify: 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 14. Race - American Indian, Black, White, etc.
11215-0036 Id be filed within 72 hours site dental Hygiene. narked other than "natural", event, the Medical Examiner	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	17. Father's Name (First, Middle, Last) Thomas Morris 18.Mother's Name (First, Middle, Maiden Surname) Helen Sudler
MD 2' nd 2 should alth and Mc em 27 is ma	P.	19a. Informant's Name/Relationship (Type, Print) William Morris/Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1906 Meadow Gate Crt., Windsormill, MD21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemelery) Date 120c Location City or Town, State
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury are nither fraumatic event, the Media		1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: John Wesley Cem. 11/17/12 Frederica, DE
Dan Derm Depa Injur	U	119 W. Cam-Wyo Ave. Wyoming, DE 19934
Physician /Medical Examiner		23a. Part I. Enter the dis-as- or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a Aortic Dissection Approximate Interval Between Onset and Death
and the second		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,
	taminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last used to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
50, te be executed ysician and burial - transit	cal Exa	d
760, cate be e	Medical	23a-b.pt.11.27.28a-f.per me,g935 1-28-13 sm
Division of Vital Records, P.O. isox 68760, Hospital ar Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detacher for use as the burial - transi	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 1 Yes 2 No 9 Unknown 1 Unknown
res that the signed by the detache	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertensive Atherosclerotic Cardiovascular Disease 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
of Vital Records, ig Physician: The law require the corrificate has been sineral director, page 2 should be	Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
icien:	8	25. Was case referred to medical examiner? [Hospital: Description
of Vining Physical After this	입	27. Manner of Death 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
Division tal nr Attendii rs after death. al Director: A	icatio	Accident See Place of Injury at home farm street factory of fire building at a 286 Place of Injury at home farm street factory of fire building at a 286 Place of Injury at home farm street factory of fire building at a 286 Place of Injury at home farm street factory of fire building at a 286 Place of Injury at home farm street factory of fire building at a 286 Place of Injury at home farm street factory of fire building at a 286 Place of Injury at home farm street factory of fire building at a 286 Place of Injury at home farm street factory of fire building at a 286 Place of Injury at home farm street factory of fire building at a 286 Place of Injury at home farm street factory of fire building at a 286 Place of Injury at home farm street factory of fire building at a 286 Place of Injury at home farm street factory of fire building at a 286 Place of Injury at home farm street factory of fire building at a 286 Place of Injury at home farm street factory of fire building at a 286 Place of Injury at home farm street factory of fire building at a 286 Place of Injury at home farm street factory of fire building at a 286 Place of Injury at home farm street factory of fire building at a 286 Place of Injury at home farm street factory of fire building at a 286 Place of Injury at home farm street factory of fire building at a 286 Place of Injury at a 286 Pl
Division To the Hospital ar Attend within 24 hours after death To the Fineral Director: completely filled in by the	Certification:	4 determined (Specify) Police Station or Town, State) 100 Railroad Ave.
Tn the Ho within 24 F To the Fu	Medical	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
		29b Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) November 10, 2012
		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature
DHMH 17 Rev 1/20	01	ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ Elsie B. Maryland 2012 0438 Oct Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Worcester Berlin Birthpic Country) Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Hours Min (Month 214-46-4040 **Director** 1 🗆 M 2 🔀 F Aug 21, 1945 67 Usual Residence of Deced iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 508 Bay Street, Apt. #15 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Black "natural", Completed 3 Widowed 4 X Divorced al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant Prep Cook 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ William Leonard other traumatic Erma Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamatha B. Nichols/daughter 508 Bay Street, Apt. #16, Berlin, MD 21811 Department of Health Important: If item 27 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 2012 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or St. Paul's Cemetery 10/27/2012 4 ☐ Donation 5 ☐ Other (Specify) Berlin, MD 21. Signatur : Fir eral Service Licensee 2. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 0 Onset and Death Immediate Cause (Final Physidian/ Chronsz obstructore disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Exami burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has autopsy performed betes Melli After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 **X**No ျ 1 Yes 1 Inpatient 2 R/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Maryland, Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

HB

State Registrar

only one 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

9733

D48130

29d. Date signed (Month, Day, Year)

Healthway Dome Ber lin MP 21811

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ Madeline Elsie Masser 5:30a lovember ONLO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Boonsboro Fahrney-Keedy Home If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Feb. 19, 1921 Maryland 214-10-5003 1 □ M 2 🗓 F 91 Director Usual Residence of Deced ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. Count 10c. City, Town or Location **Funeral Director** MD Washington Hagerstown 1 Yes 2 No 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? United States 21740 1219 Hunters Woods Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 X No Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 → Widowed 4 □ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John David Delaughter Phoebe Carbaugh 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1219 Hunters Woods Dr., Hagerstown, MD 21740 Leroy Masser (Son) 20a. Method of Disposition
1 Disposition 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Rocky Springs Center place 11/10/2012 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee Reeney & Bastord P.A. Funeral 106 E. Church St., Frederick, Home Maryland 21701 MO1612 23a. Part 1. Inter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ner tensiv Car disease or condition Medical resulting in death) Examiner Sequentially list conditions Physician/Medical Examiner Due to (as a if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ➡ No be detached for Month Day Year 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has page 2 performed Yes 2 X within 24 hours after death.

To the Funeral Director: After this certificate funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 🗖 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 11-08-2012 2323 28M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Muhammad Waseem, 1126 Opal Court, Hagerstown, Maryland 21740 31. Date filed (Month, Day, Year) NOV 1 6 2012 State Registrar

Madeline

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nhieu Thi Nguyen Oct. Day 27 9:00A M 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 213-11-0314 Days Hours **Director** 1 🗆 M 2 🗓 F 106 Jan. 6,1906 Vietnam Usual Residence of Decedent 28a-f shov permit. Pege 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "netural", or items 23e or 28a-f sho eny injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Rockville 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 Montrose Road 20852 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: Asian Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home R Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Thoi Van Nguyen Ti Thi Hoang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linh Dang Nguyen/Grandson 3716 Spriggs St., North, Frederick, MD 21704 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fairfax Memorial
Park Fairfax, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fairfax Memorial Funeral Home, 9902 Braddock Rd., Fairfax, VA 22032 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Medical Box 68760 IE FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy ō 5 Other (specify) Pregnant at time of death Month io, g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending Director: A 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital or within 24 hours aft To the Funeral Discompletely filled in NEW crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar

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O

only one) 29b. Signature and title of certifier

Babak Piroz

NOV 01 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

8600 Old Georgetown Rd., Bethesda, MD 20814

662-64

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sarah Beatrice Norris Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death **Allegany** Western Maryland Healthcare Center Cumberland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 216-38-2083
Usual Residence of Dece 1 ☐ M 2 🕱 F 94 Yrs 05/02/1918 PA or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 Yes 2 X No MD Little Orleans Allegany 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 23a with must h 13123 Spock Lane USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. or. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: "natural", White 3 X Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Quality Checker Clothing Manufacture traumatic event, Be Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumating filed \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Mary E. Barkman Albert Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis E.Norris/Daughter in law 13208 Mann Road N.E.Little Orleans, MD 21766 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 11/09/2012 Little Orleans,MD 4 ☐ Donation 5 ☐ Other (Specify) Pinev Plains 21. Signature of Funeral Serv 22. Name and Address of Facility 141 West Main Street M00260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence) disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No jo Pregnant at time of death Month Day Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should he 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ျှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 072514 MD 11/6/2012

DHMH 17 Rev 06-2011

Sho

State

Registrar

Cumberland, MD, 21502

Willowbrook Rd

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12500

31. Date filed (Month, Day, Year)

NOV 1 6 2012

			_ FOI	Department of Health and M	1ental Hygier	ne	
			- State Registra AMEND23a(a) perMD;11/7/12;BWW,MoCo	No. 20 2	37052		
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Jose Julio Ofarrill			Day Year	3. Time of Death
~~	Medic	al			10 09		11:48 P M
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral		Bethesda Health and Rehabilitatio 5. Social Security Number 6. Sex 7. Age (In yrs. last bi	rthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		place (State or Foreign
	Director		430-45-5722 1X M 2 □ F 91	Months Days Hours Min.	(Month, Day, Yea		
	T OM	١, ا	Usual Residence of Decedent 10a. State 10b. County 10c. City. Toy		04/12/192		0d. Inside City Limits
	ryland -f she ied at	to	100.01,7	wn or Location		1	1 XYes 2 No
	e Ma r 28a notifi	Pire	MD Montgomery Be 10e. Street and Number	thesda 10f. Zip Code	100	Citizen of What Cour	
	/ith th	<u>ra</u>		20814		SA	,,
	within 72 hours after death with the Maryland grein grein "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ	an Indian,
9	or it		1 X Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto 1 Xyes 2 No Specify: Cub		Black, White,	
933	ural" ural"	fed	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	TEMYes 2 I No Specify: Cdb	an	SpecifyBlack	Hispanic
5-(72 hol	gld	15. Decedent's Education (Specify only highest grade completed)	ng 16b	. Kind of Business/In-	dustry	
12	ithin ene.	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)		UNK]	
0 2	is filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be	12th 17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maide	en Surname)	
Maryland 21215-0036	s should be filed within 7 h and Mental Hygiene. 7 is marked other than traumatic event, the M	은	Jose Ofarrill	Juana	Urrutia		
lary	12 should be alth and Ment 27 is marke r traumatic e			9b. Mailing Address (Street and Number or Rura			
	1 and 2 s of Health of item 27 i			530 Wisconsin Ave. Su			
Baltimore,	t of H If itel or oth		1 Burial 2 XCremation 3 Removal from State	tery, crematory or other place)	1	. Location - City or To	
ţ	t. Pag tmen tant:		4 □ Donation 5 □ Other (Specify) Metro	politan Crem. 102 22. Name and Address of Facility Ma	20-2012 A	lexandria,	, VA
Bal	permit. Page 1 Department of Important: If is any injury or of		21. Sign tu of Funeral Service Licensee				II nome
			23a. Par 1. Enter the disease, or complications that caused the death. Do	4217 9th ST NW Was	or respiratory arrest,	DC 20011	Approximate
U,	hysician/		bock, or heart failure. List only one cause on each line Urina. Immediate Cause (Final	ry Tract Infection			Interval Between Onset and Death
	Medical		disease or condition resulting in death) a. Due to (or as a consequence	e of):			
1	Examiner		Out of the life of the land the land				
_)%;		iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence cause. Enter Underlying	e of):		33	
	ate be executed shysician and the burial-transit	Examine	Cause (Disease or injury that initiated events c.	2.00			
	cian a	dical E	resulting in death) Last Due to (or as a consequence	3 Oly.			
760	physics the b	edic	d				
.89	sertific nding use as	N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	ery
Box 687	hat the death certifical ed by the attending ph detached for use as ti	Physician/Me	in the past 12 months? 1 □ Live Birth 2 □ Fetal death			Month	Day Year
O.E	the d by the tache	hys	9 Unknown			.1	
P.O.	v requires that to been signed by should be deta	ρ	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.		co use contribute to the	he cause of death?
ds,	equire sen si rould	Completed			1 L Yes		
00	has be	nple			24a, Was an autopsy	prior to co	psy findings available empletion of cause of
Re	ician: The la certificate ha rector, page				performed	No 1 ☐ Yes	2 12 Rio
ital	ysician: is certific director,	Be c	25. Was case referred to medical examiner? 1	26. Place of Death (Check		оПои го го	
of Vital Records,	Physer this eral d	e: To	27. Manner of Death 28a. Date of injury 28b	. Time of 28c, Injury at	ome 5 L. Residence 28d. Describe how in	e 6 Other (Specify	<i>y</i>)
nc	Attending Foods to the function of the functin of the function of the function of the function of the function	icat	1 Patural 5 Pending (Month, Day, Year) 2 Accident Investigation	injury work? M 1 \sum Yes 2 \sum No			
Division	r Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street City or Town, St.	t and Number or Rura	l Route Number,
Ö	ital o						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and bondlets filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge 2 Medical Examiner: On the basis of examination and	I/or investigation, in my opinion, death occurred a	t the time, date and pl	ace, and due to the ca	use(s) and manner stated.
	To the vithin 2 to the documents of the	ž	only one) 3 Certifying Nurse Practitioner: To the best of my kn 29b. Signature and title of certifier	nowledge, death occurred at the time, date and place and place and place are also place and place are also place and place are also place are		Date signed (Month,	
	F SF Z		1 There ind	20057124		10/16/1	
			30. Name and address of person who completed cause of death (Item 23a				
				getown Road, Bethesda,	MD 20814		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registr	ar	NOV 01 2012 Januar A.	graves.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Marylar	_			Mental Hy	/giene		07050	
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of	Death	2. Date of D	Reg. No.2	12	37053	
ı	Physicia Medic		Eugene Preston Plume				Month	Day	1019 YO19	3. Time of Death 2:38 P M	
	Examin	er	4a. Facility Name (if not institution, give street and number) Julia Manor Health care		4b. City, Town, o				y of Death	10)	
	Funeral		 Social Security Number Sex Age (In yrs. I 		If Under 1 Year Months Days	If Under 24 Hi	rs. 8. Date of Bi	irth		ace (State or Foreign	
	Director		213-24-9520 1 X M 2 □ F 82 Usual Residence of Decedent	Yrs.	Wortins Days	Hours W		9,1930	Mary		
	yland f shov ed at	ctor	10a. State 10b. County 10c. Cit	y, Town or Loc					10	d. Inside City Limits	
	he Mar or 28a- or utifi	Dire	10e. Street and Number		10f. Zip Code		-	10g. Citizen of	What Count	1 X Yes 2 □ No	
	n with t	Funeral Director	1025 Security Rd.		2174	12			S.A.	, ·	
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item Z7 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.	. It	Vas Decedent of H f Yes, specify Cub: ☐ Yes 2 X No	an, Mexican, Pue	Specify Yes or No erto Rican, etc.)	Bla	ce - America ck, White, et : Whit	c.	
15-0	72 hour "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occup kind of work done	during most of w	rorking	16b. Kind of E	Business/Indu	ustry	
2121	within 7 giene. er than the M		Elementary/Secondary (0-12) College (1-4 or 5+)	Labor	D NOT use retired)			Cement	Mfg.		
Baltimore, Maryland 21215-0036	d be filed Mental Hyg arked oth	To Be	17. Father's Name (First, Middle, Last) Lloyd Wesley Plume				lame (First, Middle Irene M	,	ne)		
Man	2 shoul th and I 27 is ma traume	1	19a. Informant's Name/Relationship (Type, Print) Alice Plume-sister		g Address (Street Security					ode)	
ore,	of Heal of Heal fitem		20a. Method of Disposition 20b. F	lace of Dispo:	sition (Name of natory or other place	:	Date	20c. Location		/n, State	
tim	t. Page rtment rtant: I rjury o		4 ☐ Donation 5 ☐ Other (Specify) Ro	se Hil	1 Cemete	ry 11-	-7-2012	Hagers			
Ba	permi Depar Impor any ir once.		21. Signature of Funeral Service Licensee		. Name and Addre					al Home 1D 21742	
-4	hysician/	250	23a. Part 1. Enter the disease of complications that caused the deat shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition					rrest,		Approximate Interval Between Onset and Death	
	Medical Examiner		resulting in death) Due to (or as a consequence)	uence of):	inst	Die	10. C-4				
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	icate be executed physician and is the burial-transit	Exar	Cause (Disease or injury that initiated events resulting in death) Last	ience of):	ium Districule Colities						
09	ate be e hysicia the bur	edical	L d.								
687	certifica nding p		IF FEMALE: 23b, Was decedent pregnant 23c. If yes, outcome of pregna	ncy _				23d D	ate of deliver	· · · · · · · · · · · · · · · · · · ·	
). Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hereral birector. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1		Ectopic pregnand Other (specify)					Day Year	
, P.O.	es that signed	<u>ا ک</u>	Part II. Other significant conditions contributing to death but not res	ulting in the u	nderlying cause gi	ven in Part I.				cause of death?	
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ta	sician: certific irector,	Be	25. Was case referred to medical examiner?		Oth	ace of Death (Ch				1/1	
ot <	g Physer this	te: To	1 Yes 2 No 1 Inpatient 2 2 27. Manner of Death 28a. Date of injury (Month, Day, Year)	ER/Outpatien 28b. Time of injury	t 3 □ DOA 28c. Injur	4 Nursing y at	Home 5 Res 28d. Describe	idence 6 Oth how injury occur			
ion	ttendin death. tor: Afi / the fu	Certificate:	2 Accident Investigation			Yes 2 No					
Division of Vital	To the Hospital or Attending Physician: To the Funeral Director: After this certificacompletely filled in by the funeral director.		4 Homicide determined 28e. Place of Injury - At ho building, etc. (Specify,	me, farm, stre	et, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rural F	Route Number,	
	Hospid 24 hour Funera etely fill	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination	and/or investi	gation, in my opinio	on, death occurre	d at the time, date	and place, and du	e to the caus	se(s) and manner stated.	
	To the within Jo the comple		only one) 3 X Certifying Nurse Practitioner: To the best of n 29b. Signature and title of certifier	ny knowledge,	29c. License		I place, and due to	the cause(s) and a 29d. Date signe			
	ut		Barbara rade Sluck	er Cr	D F	11253	000	11/2	12		
	8		30. Name and address of persop who completed cause of death (Item Barbara Nakh-Bluck	23a) (Type, Pr	END-33	311:115	street, F	lawers:	hwot	, MD21740	
п	Stat Registra	e	31. Date filed (Month, Day, Year) 32. Segistrar's Signat		188						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ () Hober Jane Bernice POPE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Meritus Medical Center Hagerstown Washington 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year, Director 216-22-8561 1 □ M 2**X** F 85 Yrs 9/1/1927 Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits 1 X Yes 2 No Maryland | Washington Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21742 1635 Woodlands Run USA items 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner Black, White, etc 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and 2 should be filed within 73 Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Bank Teller Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Geraldine Wall William Foreman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Todd A. Harrison - Son 18819 Fountain Terrace, Hagerstown, Md. 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 3. permit. Page 1 Department of Important: If ii any injury or or 1 \square Burial 2 X Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) 2012 Hagerstown Crematory Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Coronary Physician/ ANTENY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner i) iscas < Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hypertension attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical that the death certificate be IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 2 No 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1060396 11/2/12 1126 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) opal MUNSHED TW-5 FARID 21740 @M HagersTown

Registrar DHMH 17 Rev 06-2011

State

Box 68760

P.O.

of Vital Records.

Division

Registrar's Signature

NOV 0 5 2012

elly Lee Pitsnog	1	State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar Certificate of Death Reg. No. 20 2	37055
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last) Kelly Lee Pitsnogle 2. Date of Death Month Day Year October 31, 2012	Time of Death
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 7927 Old National Pike 4c. County of Death Washington	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Funder 1 Year If Under 24Hrs. Months Days Hours Min. June 16, 1961 Foreign Count County Foreign County Number 1 State 1 State	lace (State or try) Maryland
v any	-	Tod. State	Od. Inside City Limits
ith the Maryland 23a or 28a-f show notified at once.		Mary Land Washington Boons boro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country	Yes 2 X No
h with the h ms 23a or be notified		7927 Old National Pike 21713 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American White, etc.	n Indian, Black,
after death wi ral", or items '	by Funeral	1 Never Married 2 X Married 1 Yes 2 X No 1 Yes Give Year or Dates: 1 Yes 2 X No specify: Specify: Whi	
imore, MD 21215-0036 Pages i and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. teat: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 O electrician 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Ind 16b. Kind of Business/Ind 16c. Vind of Business/Ind 16c. Vind of Business/Ind 16d. Vind of Business/Ind	
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than 'tie event, the Medical	Be Com	17. Father's Name (First, Middle, Last) Roy Franklin Pitsnogle 18. Mother's Name (First, Middle, Maiden Surname) Joan Marie Reed	
MD 21215 d 2 should be fill th and Mental H m 27 is marked an artic event, is	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z Rea Pitsnogle - wife 2778 Keefer Road, Chambersburg, Pa. 172	
nore, MI ages 1 and 2 s nt of Health a t: If item 27		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory 11/4/12 Hagerstown,	
Baltimore, permit. Pages I an Department of Hea Important: If itei	İ	21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME	
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Loronic Alcoholism	
	miner	if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated Due to (or as a consequence of):	
50, Le be executed sysician and burial - transit	edical Examiner	d.	
ox 68760, eath certificate be ex attending physiciar for use as the burial		UNPENDED AMENDED 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (Specify) 23d. Date of delivery Month Date of delivery AMENDED 23d. Date of delivery Month Date of delivery	y Year
O. Box that the death c ned by the atten detached for us	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the	e cause of death?
IS, P.C quires that en signed l	<u>≥</u>	Diabetes Mellitus 1	bly 4 Unknown psy findings available
Division of Vital Records, P.O. Box 6876(the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phys phytelety filled in by the funeral director, page 2 should be detached for use as the b	Completed	autopsy prior to cor performed? 1 ✓ Yes 2 No 1 ✓ Yes	npletion of cause of
Vital F nysician: this certifi I director,	8	25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other A Nursing Home 5 Residence 6 Cother: S	Scene
on of \range Phy ath. The funeral of the funeral o	tion: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Ves 2 No	
Division Bospital or Attendii 24 hours after death. Funeral Director: /	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rura or Town, State)	l Route Number, City
To the Hospit within 24 hour To the Funer completely fill	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.	l. cause(s)
E » E »	Me	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month) November 1, 2012	
ctu) 2		Se. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
ゴル・J St Regis		31. Date filed (Month, Day Year) 32. Redistrar's Signature	

OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER. 2012 3:23 PM RITA MARGARET PATRICK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8186 JUNE WAY, APT. #104 TALBOT EASTON Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Months (Month, Day, Year) Days Hours Director 216-54-9872 1 🗆 M 2 🗓 F 62 9/6/1950 MARYLAND. Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 207 DAVIS AVENUE 21601 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced WHITE Completed Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 ADMINISTRATOR MEDICAL OFFICE Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ PAUL A. DICKERSON permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic e LENA D. MOFFA 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CRISTINA M. RUZICKA, DAUGHTER 8186 JUNE WAY, APT.#104, EASTON, MD Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State Date 20b, Place of Disposition (Name of ANA de MY) (red by ar other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) REGISTRY 10/19/2012 HANOVER, MD 21. Signature of Fin 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 SOUTH HARRISON STREET, EASTON, MD 21601 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and tran Due to (or as a consequence of) burial-t resulting in death) Last physician s the burial Physician/Medical Box 68760 as attending I IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ed by the a 9 Unknown g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 Yes 2 No 3 Probably 4 Unknown been signal Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy this certificate 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes Other: 4 Nursing Home 5 Residence 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA ome 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury Natural Natural 5 Pending 1 Yes 2 No hours after death within 24 hours after death

To the Funeral Director: A
completely filled in by the f Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year, TLS 2 30. Name and address person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

OCT 1 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ 5AM 201 CATHERINE A. PASSO October Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Eastur labot Huspital at Eastor Nemomal If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 08/26/1918 PENNSYLVANIA Director 61-05-2921 1 □ M 2 🔀 F 94 Usual Residence of Dece permit. Page 1 and 2 should be filed within 72 hours efter death with the Manyland Department of Health end Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show emy injury or other traumatic event, the Medical Exactine count to notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director 1 Yes 2 X No EASTON TALBOT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21601 29365 WOODRIDGE DR. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Passo, Catherine 1 Yes 2 No Specify: Specify: WHITE 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE RESIDENCE HOMEMAKER -0-Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည MARY IVANSCHITZ JOSEPH TRENDLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WILLIAM J. PASSO/SON 29365 WOODRIDGE DR. EASTON, MD 21601 20b. Place of Disposition (Name of CROWNS Vename For other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 10/24/2012 CROWNSVILLE, MD VETERANS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee PRADOWS GOTHERNBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that cases: the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ AS ·va & Junonic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami or Attending Physicien: The law requires that the death certificete be executed attending physician and for use as the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Veal 2 🗌 No 1 Yes 2 Dunknown cate has been signed by the page 2 should be detached 9 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physicien: The within 24 hours after death.

To the Funeral Director. After this certificate I completely filled in by the funeral director, peg 2 🗆 No 1 🗌 Yes ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 NO 1 Departient 2 ER/Outpatient 3 DOA ရ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d, Describe how injury occurred Certificate: 28c. Injury at 1 Avatural 5 Pending Work? 1 ☐ Yes 2 ☐ No Division M 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2017

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Registrar

State

31. Date filed (Month, Day, Year)

OCT 1 9 2012

32. Registrar's Signature

ldress of person who completed cause of death (Item 23a) (Type, Print)
M. DESHIELDS, MD 219 S. WASHINGTON ST. EASTON, MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Physician/ Medical Examiner Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 Is merked other than "natural", or items 23e or 28e-f show eny Injury or other traumatic event, the Medical Eva niner must be notified at once. To Be Completed by Funeral Director Baltimore, Maryland 21215-0036 Physician/ Medical Examiner Medical Certificate: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

For State Registrar	State of M	aryland	•	artment of H <i>tificate of D</i>		and IV	lental Hy	gien Reg. N	20	112	3705	· {
Decedent's Name (First, Middle, Las	t)						2. Date of De		O. (J 1.	3. Time of Death	
Helen Louise Parl	ker						Month 10	2.	3 2	Year 2012	2:45 a ^N	1
4a. Facility Name (if not institution, give				4b. City, Town, or		f Death		4	c. County			
Asbury Solomons 5. Social Security Number 6. Se		irsing	hirthday)	So1omo	ns If Under:	24 Hrs I	8. Date of Bir	rth		Ca1v		
	7. A9 □ M 2 ဩ F		Yrs.	Months Days	Hours	Min.	(Month, De	ay, Year)		9. Birth Cour		п
Usual Residence of Decedent		87					12/02/	192	4		MD	
10a. State 10b. County		10c. City, T									10d. Inside City Limits	
MD Calvert		501	omons	10f. Zip Code				10- 0	Citizen of V	Afficat Cour	1 Yes 2 N	0
11750 Asbury Cir	cle, Room	200		20688				•	ited		*	
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Ar Rlack W												
1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Armed Porces? 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Will 1 Yes 2 X No Specify: Specify:											hite	
15. Decedent's Ed (Specify only highest gra	ducation	1	16a. Deced	ent's Usual Dccupa	ation	of mortin		16b.	Kind of Bu			_
Elementary/Secondary (0-12)	College (1-4 or	5+)	life. DO	O NOT use retired)			ig	n _c	nort	mont	Store	
17. Father's Name (First, Middle, Last)			Cred	dit Inves			(First, Middle				Store	
Tony Horsmon							le1en J			3)		
19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Mailin	g Address (Street a	nd Numbe	r or Rura	Route Number	er, City o	or Town, S	state, Zip	Code)	_
Debra Peyton / I	Daughter			El Merca	do Pa			_				
20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific		cem	etery, crem	sition <i>(Name of</i> natory or other place National Cen			ate ukn		Location - lingt	•	own, State	
21. Signature of Funeral Service Licens	ee	1.2.		. Name and Addres	s of Facility			al F	lome	Ca1v	ert, P.A.	_
(0)-3 - 7		d the death [Do not onto	8200 Jen					, MD	2073 1		
23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. E	e. 570	AUF	ABRTIC				rrest,			Approximate Interval Between Onset and Death	
Sequentially list conditions,	Due to (or as	a consequen	ce of):									
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	ce of):						·			
that initiated events resulting in death) Last	Due to (or as	a consequen	ce of):									
•	d									-	-	_
IF FEMALE: 23b. Was decedent pregnant in the past 12 ryonths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	eath 3 🗆	Ectopic pregnanc Other (specify)	<i>y</i>				23d. Dat Mo	te of deliventh	very Day Year	
Part II. Other significant conditions of	ontributing to death b	out not resulti	ng in the u	nderlying cause giv	en in Part I					_	he cause of death?	m
							24a. Was				ppsy findings available	
							auto	psy ormed?	/ [orior to co death?	ompletion of cause of	
25. Was case referred to medical examiner?	Hospital:				ice of Deat	h (Check	only one)					
1 ☐ Yes 2 ☐ No 27. Manner of Death	1 🗌 Inpat	ent 2 ER	/Outpatien		4 LJ Nu		me 5 🗆 Resi				y)	
1 Datural 5 Pending 2 Accident Investigation	28a. Date of inju (Month, Da		injury	28c. Injury work' M 1 🗆	at ? Yes 2□		28d. Describe	how inju	ary occume	ed		
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et		, farm, stre	eet, factory, office		:	28f. Location (City or To			er or Rura	l Route Number,	
29a. Certifier 1 Certifying Phys (Check 2 Medical Exami only one) 3 Certifying Nurs	ner: On the basis of e	xamination ar	nd/or investi	igation, in my opinio	n, death oc	curred at	the time, date	and plac	ce, and due	e to the ca	ause(s) and manner sta	ted
29b. Signature and title of certifier	0	o Douglos Hily I	o.mouye,	29c. License		⊸ uaru þiði	oo, and due to				Day, Year)	_
Ja HZ	egel us			256	35	8		0	ct.	23	2012	
30. Name and address of person who c	ompleted cause of a		Ba) (Type, P	rint) RINCE	FRE	SER	ict,	n	-6	206	2012 28	
31. Date filed (Month, Day, Year)	4 2012 (ars Signature	8	hares			· · ·					
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State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Robert L. Price AM 10 655 21 20/2 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Wicomico 4b. City, Town, or Location of Death Examiner at Coasta Salisbur Hos the Lake Pice Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days 218-40-7142 Min (Month, Day, Year) **Director** 1 X M 2 □ F Jan. 21, 1943 Maryland 69 or than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10a, State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Seaford DE Sussex 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19973 507 North Shipley Street United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) Trucking Truck Owner and Operator Be Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lee H. Price Evelyn E. Richards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 11201 Riverton Road, Mardela Springs, MD 21837 Nancy P. Massey/Sister timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 CCremation 3 Removal from State Preston, Maryland Junior Order Cem. 4 Donation 5 Other (Specify) unk 22. Name and Address of Facility Signature of Funeral Service Licenses Frampton Funeral Home, P.A. 216 N. Main St., Federal Sturg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final t-d Physician Store disease or condition Medical resulting in death) Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): igned by the attending physician and be detached for use as the burlal-transit Exam Hospital or Attending Physiclan: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has yes 2 No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence \(\subseteq\) Other (Specify) Hospital To the Hospital or Attending Physi-within 24 hours after death. To the Funeral Director: After this c completely filled in by the funeral din မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Us. ale Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year) DG3199 101 21/12, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
YOGES WHA 912 EASTEN SHOW DR. SALISBURY, MD. 21804 VOHPA YOGESH 31. Date filed (Month, Day Year) 2. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

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		1- For State Registrar		Certifi	cate of	Death			Reg. No). O.		_ 0,00		
Physicia		1. Decedent's Name (First, Middle							Death Day	Year		3. Time of Death		
Medical Exami	ner		Celley Pinde	r		0.1 T			er 29, 20	012		1130 hrs		
,		4a. Facility Name (if not institution Memorial Hospital	, give street and number)		4	b. City, Town, or Easton	Location of	Death		4c. County of Talbot	r Death			
Funeral		5. Social Security Number	6. Se x 7. Age	e (In yrs. last b	oirthday)	If Under 1 Year	r If Under	24Hrs. 8. Date	of Birth(MN	vI/DD/YYYY		hplace (State or		
Director	j		1_M 2XF	30	б _{Yrs.}	Months Days	s Hours	Min. 03/	15/19	76	Foreigr Cou	intry)Delaware		
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Location	on						10d. Inside City Limits		
*		Maryland Carol	ino		enton						ł	1 Yes 2 No		
daryland 28a-f show 1 at once.	cto	10e. Street and Number	.THE	D.	enton	10f. Zip Code			10g. C	itizen of Wha	at Coun			
th the Maryland 23a or 28a-f sho notified at once	Director	215 S. 6th Stre	act.			21629				USA				
with t		11. Marital Status	12. Was Decedent	Ever in U.S.		Decedent of His		n? (Specify Yes o	or No-	14. Race		can Indian, Black,		
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23s or 28s-f sh traumatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Ma	rried Armed Forces?	X No	If Ye	s, specify Cuban	, Mexican,	Puerto Rican, etc.)	White,	, etc.			
after	by F		rced If Yes, Give Year or Dates:			Yes 2 X No				Specify:	Whi			
hours frant		15. Decedent's Education (Speci				's Usual Occupat st of working life.			16b.	. Kind of Bus	siness/Ir	ndustry		
136 hin 72 hours afte e. than "natural", edical Examiner	Completed	Elementary/Secondary (0-12)	College (1-4 or 5)+)	Home	emaker			ĺ	Famil	v			
d with	O.	17. Father's Name (First, Middle, I	ast)				18.Mother's	Name (First, Mid						
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be (Edward Louis G	lates			1	Eliza	abeth An	n 0'N	eill				
21 nould did Mer is man		19a. Informant's Name/Relationsh		1				er or Rural Route		-		Zip Code)		
y, MD 21215-00 and 2 should be filed wi tealth and Mental Hygier tem 27 is marked other traumatic event, the M		Elizabeth A. Ga	tes/mother			S. 6th S				lary1a		21629		
S T E E		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from Sta		e of Disposit atory or oth	ion (Name of cen er place)	7.	Date		. Location -				
Page ment tant:		4 Donation 5 Other Spe	ecify:			ematory		11/1/201	2 D	over,	De1	aware		
Baltimore, MD 21215-00(5) permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Median pages.		21 Signiture of Funeral Service L	icensee // Cin	,				Moore						
	\dashv	23a Part I Enter the disease or o	1 / 1-			South 21			enton	·	216	Approximate Interval		
Physician // Medical		failure. List only one cause of	failure. List only one cause on each line. Between Onset and Death Death Between Onset and Death											
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse		lcat10	n						- Bodui		
		Sequentially list conditions,	b											
	miner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause												
	cam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):								-		
cuted and transit	I Exa	,	d											
al al	/Medical	X UNPENDED	\square AMENDED $23a$,	,27,28a	-f,pe	r me,g35	5 1-3-	-13 sm						
760, icate be physici the buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	e of pregnanc			Ectopic		23	3d. Date of o	_			
Box 68' death certiff he attending defor use as	ciai	past 12 months?	4 Pregnant at	time of death		al death 3 [er (Specify)	Ectopic	pregnancy		Month	Da	ay Year		
Boy e death the att	Physiciar	1 Yes 2 No 9 Unkr			o Our	ei (obocii)								
P.O.	D P	Part II. Other significant condition	ns contributing to death	but not result	ing in the ur	derlying cause g	iven in Parl	23e. [_	he cause of death?		
S, P.C												ably 4 🕊 Unknown		
w requ	Completed							а	Vas an iutopsy	pr	ior to co	opsy findings available empletion of cause of		
Rec The la icate ha	EO							1 🗸 Ý	erformed? es 2 i		eath? ✔ Yes	2 No		
tal Recian: The certificate	Bec	25. Was case referred to medical examiner?						Check only one)						
F Vit	٥	1 ✓ Yes 2 No	Hospital: 1 Inpatie		Outpatient			Nursing Home 5		lence 6	Other:			
After	.: ::	27. Manner of Death 1 Natural 5 Pendii	28a. Date of Injur (Month, Day,Ye	ear)	. Time of In	100	yatWork? ′es 2. X /			ijury occurre verdos		onnarcotics		
Atten r deat ector by the	cati	2 X Accident Investi	gation Id IU-Z			, factory, office b						al Route Number, City		
DIVI pital or ours afte teral Dir	Certification:	3 Suicide 6 Could determ	not be	1: Home		, ractory, orned b	allallig, otc.	or Tov	vn, State)	215 S.	6th	St.		
Division the Hospital or Attent hin 24 hours after death the Funeral Director: upletely filled in by the		202 Certifier	rsician: To the best of my			ed at the time, da	te and plac	Dento e, and due to the			as state	d.		
p i i i	Medical	(Criscoli Grill)	iner: On the basis of exan											
To wit	Me	29b. Signature and title of certifier	and manning stated.			29c. License	e number		29d.	. Date signe	d (Mon	th, Day, Year)		
		O.C.M.E. October 31, 201							2012					
	Ì	30. Name and address of person v		,	,									
		Ana Rubio M.D., Ph. D				vv. Baltimore	Street,	≾altimore, ME 	21223	<u></u>				
St Regist		31. Date filed (North Day, Y201)	2 October 1	's Signature	arked									
	_													

			State of Maryland				Mental Hy	giene 201	2 37061
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	<i>Jeatn</i>	2. Date of Dea	Reg. No.	0.77
-	Physicia Medic		Shaeedah Quinones			_	Octobe	r 23 20°	
	Examin	er	4a. Facility Name (if not institution, give street and number) 16703 Governor Bridge Rd#30	١7	4b. City, Town, or Bowie	Location of Deat	h	4c. County of Drings	George's
The state of the s	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Year	If Under 24 Hrs		h g.	Birthplace (State or Foreign
2	Director		579-68-8313 1 1 M 2 X F 65	Yrs.	Months Days	Hours Min.	(Month, Day	, Year) , 1947 Wa	Country) SshingtonDC
	nd how at	ᅵᅟႍ	Usual Residence of Decedent 10a. State 10b. County 10c. City, 7	fown or Loc	cation				10d. Inside City Limits
	faryla Ba-f s tified	Director	Md Prince George's Bowi	ie					1 X Yes 2 No
	the N	اق	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha	t Country?
	ns 23 must	Funeral	16703 Governor Bridge Rd#30		20716			USA	
	r deat or iten niner i	by Fu	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2√7 No	13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (S n, Mexican, Puerl	pecify Yes or No- to Rican, etc.)		American Indian, Vhite, etc.
036	rs afte iral", o Exan	ed b	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No If Yes, Give Year or Dates.	1	☐ Yes ※☐ No	Specify:		Specify: B	lack
15-0	2 hou "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occupa kind of work done d	ation Juring most of wo	rking	16b. Kind of Busin	ess Industry
121	within 72 hours after death with the Maryland giene. gret than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)		ONOT use retired) $\mathbf{nting} \ \mathbf{T} ($	echnici	lan	Federal	Government
102	be filed w ental Hygi ked other ic event, t	Be	17. Father's Name (First, Middle, Last)					Maiden Surname)	
Vlar	d be f Menta arked atic ev	욘	George Gross			Doris	Rivers		
Mar	ge 1 and 2 should be filed within 72 hours after death with the Maryland ti of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at							r, City or Town, State	
e, l	and 2 Health em 2:		Kertia McSterling(Daughter) 20a. Method of Disposition		Englis sition (Name of	h Oaks	Ave Bo	Wie Mary 20c. Location - Cit	
nor	age 1 ent of nt: If it		1 Burial 2 To Cremation 3 Removal from State cem	netery, crem	natory or other place				Le Maryland
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		21. Signature / Fuperal Service Licensee		. Name and Addres		23,121		VashingtonDC
ä	a III o	113	sprone four	≺ Ţy	rone J.	Young	5635 E	ads Stre	eet Ne. 20019
			23a. Part 1. Emer the disease, or complications that daused the death. I shock, be heart failure. List only one cause on each line.	Do hor ente	er the mode of dying	g, such as cardia	c or respiratory arr	rest,	Approximate Interval Between Onset and Death
	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	infa	rction/	Cardia	c arrhy	thmia	Onset and Death
37.	Examiner		Coronary Ar		diense	0			vears
		iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	es of,:-	OLD COD				7.01.0
	cuted and transit	xam	Cause (Disease or iinjury that initiated events c. Diabetes and		pertens	ion			years
	ate be executed physician and the burial-transit	dical Examiner	resulting in death) Last Due to (or as a consequent	ce oij.					
292	icate by physis the l	ledic	d					1	
x 687	attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal d	y leath 3 [Ectopic pregnanc	ēv.		23d. Date of	
Вох	the att	Physician/Me	in the past 12 months? 1 Yes 2 XNo 9 Unknown 1 Ves 12 No 9 Unknown		Other (specify)			Month	Day Year
P.O.	es that the dea signed by the a be detached f		Part II. Other significant conditions contributing to death but not result	ing in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use contribu	te to the cause of death?
S, F	uires that n signed uld be del	ed by					1 🗆	Yes 2 X No 3 l	Probably 4 Unknown
Sorc	sician: The law require certificate has been si rector, page 2 should	Completed					24a. Was	an 24b. Wer	e autopsy findings available r to completion of cause of
Rec	The la	Com					perfo	rmed? dea	th?] Yes 2 🗌 No
ta	ician: certific ector,	Be	25. Was case referred to medical examiner?		Othe	ace of Death (Che			
of V	Attending Physician: The le er death. ector: After this certificate he by the funeral director, page	e: To		Bb. Time of	nt 3 🗆 DOA	4 L Nursing	T	dence 6 Other (S	Specify)
uc	inding ath. r: Afte ie fune	icat	1 X Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation	injury	work	? Yes 2 🗆 No			
Division of Vital Records,	I or Atten after deat Director: I in by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (S City or Tow		r Rural Route Number,
Ä	pital o		29a. Certifier 1 Certifying Physician: To the best of my knowled	lae death (occured at the time	date and place	and due to the ca	use(s) and manner a	s stated
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlal-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physician: 10 the best of my knowled only one) 1 Certifying Nurse Practioner: To the best of my knowled	nd/or invest	tigation, in my opinio	on, death occurred	at the time, date a	and place, and due to	the cause(s) and manner stated.
	To the within To the comp	<	29b. Signature and title of certifier		29c. License	number		29d. Date signed (N	fonth, Day, Year)
			1 J.C. MD		D6922	21		October	25th 2012
	JM		30. Name and address of person who completed cause of death (Item 2:			. V	inctor	Marrian	d 2090E
	Sta	te	Robert Trimble MD 10810Conr 31. Date filed (Month, Day, Year) 32. Registrar's Signatur	. 0	4	, rens	THG COH,	mar yran	u 20095
	Registra	ar	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	Mark.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 –** For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCF Month Physician/ Year 45 DING Medical Eacility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltmore pult more WHERAN home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Director** 94 218-05-2767 1 M 2 X F MD. 10/04/1918 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD. Baltimore Baltimore 1 Tes 2 No Citizen of What Country? 10e. Street and Number 10f. Zip Code 6811 Campfield Road 21207 death v 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 【 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", Specify: White 3X Widowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Printing Estimator event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rudolph W. Roeth Robina Rolph permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21784 6701 Chateau Bay Ct. Sykesville MD. Ian Radcliffe / Nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial X Cremation 3 Removal from State Delmar, DE. of Delmarva 10/26/12 Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HumleyAddes Ostrowski Funeral Home P.A. P.O. Box518 St. Michaels, MD. I oseph 21663 m. Osticowski C.F.S.P Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Schl mic disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to (or as a consequence of): than, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami tra resulting in death) Last Due to (or as a consequence of): at ending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Day Month Year the a Unknown P.O. ed by t detach signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform certificate 2 🗌 No 1 🗌 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Asisted Living 1 Tes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work 1 Tyes 2 🗌 No 2 Accident
3 Suicide within 24 hours after death

To the Funeral Director: /
completely filled in by the Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

TLS

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

Ella Krupintshaya C.N.P. 2835 Smith Ave. Ste. 203 Baltimore MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State OCT 2 6 2012 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

32 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ 06 2012 Medical 4b. City, Town, or Location of Dea...

Barbaro HD 2013

If I Inder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Sept. 23, 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death washine Fahrney-Keedyttonic 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Country) 490-34-5349 **Director** 1**X** M 2 □ F 79 MO 1933 28a-f show 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD XX Yes 2 No Washington Boonsboro 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8507 Mapleville Road 21713 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin once. þ 1 Never Married 2 X Married Robertson 1 Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Korean Completed Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Minister Religion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) August W. Robertson Irma S. Vass Stephen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia G. Robertson/wife 20014 Rosebank Way, Hagerstown, MD Page 1 and 2 Date 10, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Ft. Loudon, PA Stenger Hill 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Lininger-Fries Funeral Home Inc. tues Park Ave., Mercersburg, PA 17236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Devocusiu burial-trar that initiated events Diff to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 □ No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Completed by be 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I autopsy performed Yes 2 2 🗌 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes Certificate: 28b. Time of 28d. Describe how injury occurred injury Vatural 5 Pending 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2323 -2012 Name and address of person who completed cause of death (Item 23a) (Type, Print)

V. Khalid Wascer, HD 1124 Opal Court Hagerstown, HD 21740 egistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ Dear Kenner 4:10 P illiam 2012 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Juliananor Healthcase Huserstown Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Director 214 09 0367 1 🗶 M 2 🗆 F 96 March 10,1916 Hagerstown,MD Usual Residence of Dec show 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location at Completed by Funeral Director notified 28a-f 1 Yes 2 No MD Hagerstown Washington 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20 must be 23a 17800 Virginia Avenue 21740 items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ral", or iten Examiner Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify 3 ▼ Widowed 4 □ Divorced Specify: White "natural", Army Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Grace Elizabeth (Boward) Renner Thomas A. Renner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health art: If item 27 is you other train 17752 Virginia Ave.,Hagerstown,MD 21740 Laura A. Bowers/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department o Important: If any injury or Smithsburg Crematory Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home Signature of Funeral Service Licenses Potomac St., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotio disease or condition resulting in death) Medical Examiner Spiration procumous Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying th Behaviora Disturbano Cause (Disease or injury that initiated events resulting in death) Last recular Dementio and the burial-trar Due to (or as a consequence of attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No for Month Year Dav Pregnant at time of death be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 24a Was an ate has b autopsy certificate Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 X Natural work?
1 Yes 2 No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 0 R125360 CZ

DHMH 17 Rev 06-2011

State Registrar

8+1VA

RND-333 Milistreet, Hoverstown, MD 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

Kegistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month October Physician/ 2012 5:30 P Patricia Massing Reynolds Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Country) 81 577-46-1275 Director 1 ☐ M 2 🚰 F Aug. 23, 1931 DC "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. Count Director 1 Yes 2 No Montgomery Silver Spring 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Funeral 20906 USA 2900 N. Leisure World Blvd. #503 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Specify:White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ã No Specify: 3 Widowed 4 Divorced Completed Year or Dates al Hygiene. I other than "natura vent, <u>the Medical E</u> 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 should be filed with lith and Mental Hygien 27 is marked other the r traumatic event, the <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ William Peter Massing Gertrude Hearn Page 1 and 2 should 20906 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2900 N. Leisure World Blvd. #503, Silver Spring, MD Joseph C. Reynolds/Husband of Health 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Nov. 2<u>01</u> permit. Page 1 Department of I Important: If it any injury or o 1 E Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Silver Spring, MD 21. Signature of Juneral Service Lie 22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc. Ja ten TchardI MD 20901 500 University Blvd. W. Spring. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ a Acute Respiratory Failure Medical resulting in death) Due to (or as a consequence of): Examiner Interstitial Lung Disease Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and re burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial: transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 🗌 Yes 2 🔲 No 1 ☐ Yes 2 ☒ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖾 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 유 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 - Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5 October 30, 2012

State

Registrar

1500 Forest Glen Road, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Nabila Khan, MD
31. Date filed (Month, Day, Year)

NOV 01 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 19a-b, per INF, g933 11-26-12 sm
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBES Physician/ Lisa Rolanda Ramey 2012 Medical 4b. City, Town, or Location of Death **Lanham** 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** Doctors Community Hospital Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Hours 579-98-9096 Director 1 M 2 XF 47 Wash. DC 01-31-1965 or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland must be notified at Director Lanham 1X Yes 2 ☐ No MD PG 10e. Street and Number 10g. Citizen of What Country? Zip Code 20706 or items 23a Funeral 8910 Walkerton Dr. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. ò 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Black 1 ☐ Yes 2 X No Specify Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nelson Althea Ramey Maurice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Isaiah Weston/Husband Michael Brown Jr./Son 8910 Walkerton Dr. Lanham, 124 Monich Rd. Orangeburg Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11-05-2012 Waldorf, MD Heritage Mem. Pk 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald Taylor II FH Conoal 10583 Middleport In. White Plains, MD 20695 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, h line. 23a. Part 1. Enter the disease, or complications of shock, or heart failure. List only one cause of Interval Between Onset and Death Immediate Cause (Final Physician neumoni disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months? Month Day Year signed by the at 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director. After this certificate homoletely filled in by the funeral director, pag 1 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🕱 No Other: IXnpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) SM who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person ABDULWAH ROAD. LOZIA Good Luck

Registrar

DHMH 17 Rev 06-2011

State

32. Registrar's

			State of Maryland / Depar		1ental Hyg	jiene					
			riogional	ficate of Death		Reg. No. 20 2 37067					
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Dea Month		3. Time of Death Year				
	Medic	al	Clyde Augustus Roberts, Jr. 4a. Facility Name (if not institution, give street and number)		October 0						
	Examin	er		4b. City, Town, or Location of Death		4c. County of					
	Funeral		Asbury Health Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Solomons If Under 1 Year If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign				
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	or 28a notif	Dire	Maryland Calvert Solomons 10e. Street and Number	10f. Zip Code		10g. Citizen of Wh					
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If of Health and Mental Hygiene. If filem 27 is marked other than "natural", or items 23a or 28a-f show it filem 27 is marked other than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	eral	11750 Asbury Circle, RM 227A	20688		United S					
		Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	is Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race	- American Indian,				
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ტ ტ	and 2 s Health tem 27 other tra		Marybeth Gallot / Daughter 1337 R 20a. Method of Disposition 20b. Place of Disposit	iver Oak Drive, N	Napervil Date		DU565 Dity or Town, State				
Baltimore,	permit. Page 1 a Department of I Important: If its any injury or of		1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crema	tory or other place)							
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, B0X	the a	Physician/Med	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)							
J.	hat th ed by detac		Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause given in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?				
Ś.	n sign	ed by	PRUSTATE CANCEL		1 🗆 🗅	∕es 2□No 3	3 Probably 4 Unknown				
Vital Records,	v request special should	Completed			24a. Was a		ere autopsy findings available				
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Ξ	hysic his ce Il dire	으	1 Yes 2 146 Hospital: 1 Inpatient 2 ER/Outpatient		ome 5 🗌 Resid	ence 6 Other	(Specify)				
10	Attending Physician: The law requires that the death acts death. ector. dath. ector. Atthe this certificate has been signed by the atte by the funeral director, page 2 should be detached for	Certificate:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury	work?	28d. Describe h	ow injury occurred	d				
<u> </u>	deatl ctor: y the	tific	2 Accident Investigation 3 Suicide 6 Could not be		28f. Location (S	treet and Number	or Rural Route Number,				
DIVISION	after Direc		4 Homicide determined building, etc. (Specify)	,,	City or Tow		5, 113, 21, 115, 115, 115, 115, 115, 115, 115,				
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	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completed filled in by the funeral.	Me	(Check 2 ☐ Medical Examiner: On the basis of examination and/or investig only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, de	ath occurred at the time, date and place	ce, and due to the	cause(s) and man	nner as stated.				
			29b. Signature and title of certifier	29c. License number			(Month, Day, Year)				
	10+1		30. Name and address of person who completed cause of ceath (Item 23a) (Type, Pri	D26358		Uctobe	er 22, 2012				
	KM	John H. Weigel, MD 110 Hospital Road, Suite 310, Prince Frederick, MD 20678									
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	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2012 37068										
_	Registrar 1. Decedent's Name (First, Middle, Last)				Cert	ilicate of L	Jeann	Reg. No. 2 U Z 3 / L 2. Date of Death 3. Time of D			3. Time of Death
	Physicia Medic		Karagen Rose R				Octobe	Day 23	2012	1:30 P M	
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	-	202 Cool Spring Road [5. Social Security Number				Hender If Under 1 Year	son If Under 24 Hrs.	8. Date of Birth	Caro	line 9 Birthol	ace (State or Foreign
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Maryland	d Men marke matic		Jonathan Richard Rob 19a. Informant's Name/Relationship (Type, Print)		401. M-10.		Crystal and Number or Run		City or Town	State 7in C	adal
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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal fro		e of Dispos	ition (Name of atory or other place			20c. Location		wn, State
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89 ×	r use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, € 1 □ □ □		Ectopic pregnance	су			Date of delivery		
P.O. Box 687	requires that the death certifics been signed by the attending p should be detached for use as i	Completed by Physician/Me	1 Ves 2 700	regnant at time of dea nknown	th 5 🗌	Other (specify)			M	onth	Day Year
<u>о</u> .	hat the	y Ph	Part II. Other significant conditions contributing to	death but not resulti	ng in the ur	nderlying cause gi	ven in Part I.	23e. Did tob	acco use con	tribute to th	e cause of death?
	quires quires an sign	ed b	1 \(\text{Yes} \) 2 \(\text{NNO} \) 3 \(\text{NNO} \)							3 Prob	ably 4 🗆 Unknown
COL	aw rec las bee	nplet						24a, Was ar autops	SV	prior to cor	osy findings available inpletion of cause of
Re	r: The icate h	ပ္ပ	OF Wissess referred to seeding					perform		death?	2 No
/ita	/siciar s certif	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital:	☐ Inpatient 2 ☐ EF	VOutpatien	_ Oth	ace of Death (Check only one) er: 4 Nursing Home 5 Residence 6 Other (Specify)				
of	ng Phy ter this	te: 1	27. Manner of Death 1 Natural 5 Pending 28a. Da (M)	b. Time of injury	28c. Injur work	y at	28d. Describe how injury occurred				
ion	or Attendil after death. Director: At in by the fu	Certificate:	2 Accident Investigation	fauna atua		Yes 2 □ No	28f. Location (Street and Number or Rural Route Number,				
Division of Vital Records,	after of Direct of in by	Cerl	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)			et, ractory, office		City or Town, State)			noute Number,
ш	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To th	e best of my knowled	ge, death o	ccured at the time	e, date and place, a	nd due to the caus at the time, date an	se(s) and man	ner as state	d. use(s) and manner stated.
	the H thin 24 the F	Me	only one) 3 Certifying Nurse Practions 29b, Signature and title of certifier	er: To the best of my kr	nowledge, d	eath occurred at th	e time, date and pla	ce, and due to the	cause(s) and n	nanner as sta	ated.
	.P. 3 P. 8		296, Signature and title of certifier Labolium Vandyana	than N	17			_			4 2012
			30. Name and address of person who completed c	ause of death (Item 23	Ba) (Type, P	rint)					
			LAKSHMI VAIDYANA 31. Date filed (Month, Day, Year) 32. 32	THAN 21	95.	WASHIN	IETON ST	EASTO	nd in	D 21	601
	Sta Registr		31. Date filed (Worth, Day, Tear)	. Registrar's Signature	A. 1	merch					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Robertson Physician/ 9:45 PM ford Barr JR. 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner at Salisbur comico TOSPICE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Months Hours 114-36-7696 **Director** 1 M 2 🗆 F 66 New Usual Residence of Decedent 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 🗌 Yes 2 🕱 No Somerse Westover Maryland 10f. Zip Code 10g. Citizen of What Country? Funeral Millard Long Rd 21871 U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black, White, etc. Armed Forces?

1 May Yes 2 □ No
If Yes, Give 1965-69
Year or Dates. þ 1 Never Married 2 Married lifford B. Robertson Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No Specify: Black Completed 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) Verizon Coordinator 11th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sr. B. Robertson Anna Cotton Clifford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Church St Princess Anne, MD, 21853 Chakenya 20a. Method of Disposition Robertson-day Apt. B 116 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 Cremation 3 🗆 Removal from State 11/11/12 4 Donation 5 Other (Specify) Crematory of Delmarva Delma-, Delaware Ward Jr. F.H. 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Anthony E. 30639 Ave Princess Anne, MO, 21853 Hampden 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicians ARCINOUNT NAC MALIa Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to or as a consequence of cause. Enter Underlying use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ding physician Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Day 5 Other (specify) Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s death? 1 ☐ Yes 2 ☐ No certificate Yes **Division of Vital** 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital: HOSPECR ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 \square Yes Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 5 Pending 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one re and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UlAm 1180 L Bol 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

NOV 0 1

Physician /Medical Examiner

Funeral Director

28a-f show injury or other traumatic event, the Medical Examiner must be notified at ò Pages 1 and 2 should be filed within 72 hours after death is marked other than pormit. Pages 1 and 2 should be filed within D. partment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the stange of other presents are injuried.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed Box 68760 P.O. Records, Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year October 30 2012 George W. Stover, Jr. 6:04 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death White Plains 4225 Southwind Place #116 Charles If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Hours Months Days 1**X** M 2□ F 78 579-40-4726 1 - 6 - 34Wash. DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1XYes 2 No Director MD. Charles White Plains 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 4225 Southwind Place, #116 20695 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2 XNo 1 Never Married Married 1 ☐Yes 2X No If Yes, Give Year or Dates: Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Labor Relations Spec. Dept. of Labor 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Clark ဥ George W. Stover, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20695 19a. Informant's Name/Relationship (Type. Print) Deloris Stover/Wife 4225 Southwind Pl. #116 White Plains, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/7/12 4 ☐ Donation 5 ☐ Other (Specify) Heritage Memorial: Waldorf, Md. 21. Signatur of Funeral Service Licensee Hackett's Funeral Chapel, Inc. 814- Upshur Street, NW DC 20011 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ascular Immediate Cause (Final disease or condition resulting in death) Pes phosa Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Yes 2 No 3 Probably W Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2**X** No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D28352 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S-102 Krishan M. Mathur, M.D. 3500 Old Washington Rd. Waldorf, Md 20602

Registrar DHMH 17 Rev 1/2001

State

(Month, Day, Year)
NOV 0 1 2012

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23a.pt.Ib-c, 23b,pt.II, 25,27,28a-f,per me,g934 12-28-12 State of Maryland / Department of Health and Mental Hygiene 20 2 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year HELEN SPIES 12:00 AM October 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arden Courts Assisted Living Montgomery Potomac 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Feb. 16, 1 □ M 2 🗓 F OHTO 300-10-8637 91 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director MD Montgomery Rockville 1 ☐ Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 9801 Sunset Drive 20850 IISA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 'natural", or by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify 3[™] Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Financial Management Accountant is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Howard John Stone Helen LaSance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joelen Stone Frank/Niece 9801 Sunset Drive, Rockville, MD 20850 Department of Healt Important; If item 2 any injury or other tonce. Date 5 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. b, 2012 1 🖾 Burial 2 🗌 Cremation 3 🔯 Removal from State San Fernando Mission 4 Donation 5 Other (Specify) San Fernando, CA Cemetery 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc 500 University Blvd. W., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HEMORRHAGE Onset and Death Immediate Cause (Final Physician/ INTRACRANIAL 0 disease or condition resulting in death) Medical Due to (or as a consequence of): Traumatic Brain Injury Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of TON APPROVED BY MEDICAL EXAMINER as the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last physician Physician/Medical IF FEMALE: use a 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months Month Year Day 2 WNox No a Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, F Advanced Dementia 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of Failure To Thrive 24a. Was an certificate has autopsy page death? 2 🗌 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) LIVING FACILI Hospital: Other: မှ 1 Inpatient 2 Inpatient 3 Inpa 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury work? 1 ☐ Yes 2 🔀 No 1 Natural 5 Pending subject fell 24 hours after death. Funeral Director, Af X Accident 10-18-2012 | unknown^M Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10718 Potomac Tennis 4 Homicide determined Ln. Potomac, MD. Nursing Home 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0057458 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
Pinky Singh, MD 8218 Wisconsin Avenue, #305, Bethesda, MD 20814 31. Date filed (Month, Day, Year 32. Registrar's Signature State NOV 01 2012 Registrar

	State of Maryland / Department of Health and Mental Hygiene											
		1 - State Registrar Certificate of Death Reg. No. 2						2012	2 37072			
	Physicia	n/	Decedent's Name (First, Middle, Last)					2. Date of Month		y Year 2012	3. Time of Death	
	Medic	al	Cecelia Mary Spera 4a. Facility Name (if not institution, give street			4b City Town o	r Location of Deatl			. County of Dea	10:00 p ^M	
	Examin	er	Montgomery Hospice-(•	ville			ontgome		
	Funeral		5. Social Security Number 6. Sex	birthday)				B. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)				
	Director		220-46-9447 1 □ M Usual Residence of Decedent	2₺F 94	Yrs.				20, 19		anada	
	and show at	٥	10a. State 10b. County	10c. City, To	own or Loc	ation	1				10d. Inside City Limits	
	Maryla 28a-f	rect	FL Broward	Laud	derdal	Le-by-the	e-Sea	_			1 🏝 Yes 2 □ No	
	h the ka or 2 be no	al Di	10e. Street and Number	-		10f. Zip Code			1 -	itizen of What C	Country?	
	th with ms 23 must	Funeral Director	280 Codrington Driv	Was Decedent Ever in U.S.	12 14	33308	lispanic Origin? (S	nacify Ves o		USA 14. Race - Am	perioan Indian	
(0	er des or ite niner	by Fu		Armed Forces? 1 Yes 2 No	lf lf	Yes, specify Cuba	an, Mexican, Puert	o Rican, etc	5.)	Black, Wh		
က္က ဂြ	ırs aft ural", I Exal	ted		If Yes, Give Year or Dates.	1	☐ Yes 2 Ñ No	Specify:			Specify: WIII	100	
5 -(72 hou	Completed		15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during mos life. DO NOT use retired)				ost of working			s/Industry	
72	vithin iene. rr thar the M		Elementary/Secondary (0-12)	College (1-4 or 5+)		emaker			0	wn Home	<u> </u>	
פַ	filed val Hyg	Be	17. Father's Name (First, Middle, Last) Allessandro Missori				18. Mother's Na					
Хa	ild be Ments larked	၉	Allessandro Missori				l		1 Sign			
Mar	2 shouth and it is in traum		19a. Informant's Name/Relationship (Type, I JOan Sperapani Cari	Print) no/Daughter			and Number or Ru ton Road,					
ē,	l and lifem 2		20a. Method of Disposition	20b. Plac	e of Dispos	sition (Name of	1	Date		ocation - City		
ê E	Page nent o int: If		1 🖺 Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)	noval from State Gatt		feaven pla etery	ce) Nov	2012	Sil	ver Spr	ing, MD	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show amy injury or other traumatic event, the Medical Examiner must be notified at ance.		21. Signature Funeral Servin Licensee		Fi	Name and Addre	ss of Eaglityins	Fune	ral Ho	me Inc.		
ш	70 E # 9		23a. Part 1. Enter the disease, or complicat							er Spri	Ing, MD 20901	
٦.	beath certificate be executed E at the burial transit of for use as the burial transit of for use	D (1	shock, or heart failure. List only one ca	ause on each line.					ory arrest,		Approximate Interval Between Onset and Death	
f			disease or condition resulting in death) Chronic Obseructive Pulmonary Disease Due to (or as a consequence of):								-	
		nine	if any, leading to immediate	equence of):								
		Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								<u> </u>	
00	s be ey sician e buris	dical										
876	ifficate ng ph) as th	Med	IE EEMALE.					-				
Box 687	The past 12 months? 1 Ves 2 No 9 Unknown 1 Unknown Unkno						су				3d. Date of delivery Month Day Year	
<u> </u>	re dea	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 U Pregnant at time of dea 9 Unknown	am 5∟	Other (specify) _			_			
<u>о</u> .	requires that the des been signed by the a should be detached	by P	Part II. Other significant conditions contrib	outing to death but not result	ing in the u	nderlying cause g	iven in Part I.	23e	. Did tobacco	use contribute	to the cause of death?	
ds,	quires en sign ould b	P P							1 🗌 Yes	2 □ No 3 □	Probably 4 🖾 Unknown	
CO	has be	Completed						- 1	. Was an autopsy	prior t	autopsy findings available to completion of cause of	
æ	ysician: The Is is certificate ha director, page	ပိ							performed? Yes 2 1	vo 1 🗆 🗅	Yes 2 No	
/ital	sician: The certificate lirector, pag	Be Be	25. Was case referred to medical examiner? 1 Yes 2 No	oital: 1 ☐ Inpatient 2 ☐ EF	2/Outpotion	Oti	Place of Death (Chi	-		6 MHASB	Lce	
_	ding Phys th. After this funeral di	te: 70	27. Manner of Death		Bb. Time of injury		ry at		cribe how inju		ecny	
ion	Attendin er death. ector: Af by the fu	ifica	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be			M 1	Yes 2 No					
Division of Vital Records,	after deat after deat Director: In by the	Certificate:	4 Homicide determined 28e. Place of Injury - At ho building, etc. (Specify,			eet, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Δ	ospital hours ineral ly fillec	Medical	29a. Certifier 1 Certifying Physicia	n: To the best of my knowled	lge, death o	occurred at the tin	ne, date and place	, and due to	the cause(s)	and manner as	stated.	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transic.	Med	only one) 3 Certifying Nurse P	On the basis of examination a ractitioner: To the best of my	knowledge,	death occurred at	the time, date and	place, and o	due to the cau	se(s) and manne	ar as stated.	
			29b. Signature and title of certifier	lippon -	110	29c. Licen:				ate signed (Mo		
			30. Name and address of person who comp	MATO CR	3a) (Time 5		7201			0.31-1	2_	
			Debrah Miller, CRN	IP 1355 Picc	card I	rive, Ro	ockville,	MD 2	.0850			
	Sta		31. Date filed (Month, Day, Year)	37. Registrar's Signatur	par	Kel.						
	Registr	ar	NOV 01 2012	Chaus B.	7	,						

			State of Mary		artment of F			21	112	37073
			Registrar 1. Decedent's Name (First, Middle, Last)	007	till cate of L	, cati	2. Date of Dea	Reg. No.		
	Physicia		Charles F. Stouter				Octobe:	r 23, 2	01°2	4:30 a м
	Medic Examin		4a. Facility Name (if not institution, give street and number) St. Joseph's Ministries			Location of Death		4c. County of Death Frederick		
	Funeral Director		. Nr	yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Feb 23	Year) 1925	g. Birthp Count Mary	place (State or Foreign try) Land
	d t t		Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or Loc	cation				1	Od. Inside City Limits
	arylan a-f sh ified a	ecto	Maryland Frederick	, c.		Emmitsbu	rg			1 🗆 Yes 2 🗷 No
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "latural".	Funeral Director	10e. Street and Number 16751 A Scott Road		10f. Zip Code	21727		10g. Citizen of What Country? USA		
	eath wi tems 2 er mus	Fune	11 Marital Status 12. Was Decedent Ever	r in U.S. 13. V	Vas Decedent of Hi	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No-		ce - Americ	an Indian,
9	after d I", or i xamin	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		Yes 2 No		moan, etc.,	Specify	ck, White, e	ite
2	hours natura lical E	lete	15. Decedent's Education	16a. Deced	lent's Usual Occup	ation	·	16b. Kind of E		
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Z Z	iled wit I Hygie other /ent, th	Be	12 17. Father's Name (First, Middle, Last)		OWING	18. Mother's Nam	e (First, Middle, i	Maiden Surnam	re)	-
Maryland	uld be f Menta narked natic ev	욘	Felix Stouter				Hardma:	n; City or Town, State, Zip Code)		
~	○ 〒 2 車 2 車	- 3	19a. Informant's Name/Relationship (Type, Print) Gary Stouter, son	19b. Mailin	ng Address (Street a 25 Scott	and Number or Rura Road, Emm	nitsburg	, MD 21	727	Jode)
Baitimore,	je 1 and t of Hea If item or other		1	20b. Place of Dispo cemetery, cren	4	-1	Date 7 / 201 2	20c. Location		
<u>=</u>	permit. Page 1 Department of Important: If i any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	New St. J	Joseph's Name and Addre	cem 10/2	yers-Dur			
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	hysician Medical Examiner	250	2 s. Part 1 Enter the disease, or complications that au d the shock, or heart failure. List only one cause on y chille. Immediate Cause (Final disease or condition resulting in death) Due to (or as a condition from the condition for the conditio	ronne	er the mode of dyin	g, such as cardiac		est,	-	Approximate Interval Between Ofiset and Death
	Lamine	Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a co	onsequence of):						
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ဂ္ဂ	be exe sician a burial-	dical E	resulting in death) Last Due to (or as a co	onsequence oi).						
. Box 68/6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ě	IF FEMALE: 23c. If yes, outcome of page 1	☐ Fetal death 3 ☐	Ectopic pregnand Other (specify)	Бу			ate of deliv	ery Day Year
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Division	or Atter after de Directo in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (5	- At home, farm, str Specify)	eet, factory, office		28f. Location (S City or Tow		ber or Rura	I Route Number,
	Hospital 24 hours Funeral ted filled	Medical	29a. Certifier 1 Certifying Physician: To the best of my (Check 2 Medical Examiner: On the basis of exam	mination and/or inves	tigation, in my opini	on, death occurred a	at the time, date a	ind place, and d	ue to the ca	iuse(s) and manner stated.
	To the within 2 To the comple	ž	only one) 7 Certifying Nurse Practioner: To the best 29b. Signature and tipe of certifier	st of my knowledge,	29c. Licens	e number		29d. Date sign		
			I Man Ca	www		018705		10/0	23/1	2
6	X710		30. Name and address of person who completed cause of deat Alaw 310		on Ave	Emm	itsb	urg 1	MD	2172)
i	Sta Registra		31. Date filed (Month, Day Year) 32. Refistrar's OCT 2 4 2012	Signature .	barre					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october ^Df^y8, 2012 7:45 pm Elizabeth Sirian Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Emeritus at Westminster Carroll Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 4, 1924 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours Min Maryland 220-14-6459 88 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗆 Yes 2 🔀 No Maryland Carroll Westminster 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 45 Washington Road, unit 213 21157 HSA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates white Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Hygiene. College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Registered Nurse Medical 2 should be filed with h and Mental Hygien. 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Louis H. Pohl Dorothy Jones traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh.
Department of Health an
Important: If item 27 is 1 45 Washington Rd, unit 213, Westminster, MD 21157 Ralph Sirian, husband 20a. Method of Disposition 20c. Location - City or Town, State Date 20b Place of Disposition (Name 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Coth Coth Companies 10/22/12 Timonium, MD Memorial Gardens Signature of Funeral Service License 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis St, Westminster, MD 21157 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the caused the death. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) -transit Exami Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last the burialattending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month 1 Yes 2 No 9 Unknown Day Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 Tes 2 No Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?
1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. Manner of Death 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Natural 5 Pending work? 2 🗆 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chaek Certifying Nurse Frantioners to best of my knowledge, death or 6ignature/and 29c License number

State

Box 68760

P.O.

Division of Vital Records,

DHMH 17 Rev 7/2009

Registrar

who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:15 PM Catherine M. Shunk COTOSE 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner Meritus Medical Center Washington Hagerstown Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Hours (Month, Day, Year) 209-28-9347 90 Director 1 🗆 M 2 🗆 🗙 Nov. 26, 1921 Pennsylvania Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County notified at Director Maryland Washington Hagerstown 1 Yes 2 XNo 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? o must be with t 23a Funeral 19800 Tranquility Circle 21742 U.S.A. items ? death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11 Marital Status an "natural", or iter Medical Examiner Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. If Yes, Give Year or Dates White 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) the **T.PN** Hospital should be filed with and Mental Hygien is marked other th event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John Andrew Woytek Mary Ann Wovtek permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21110 Mt. Aetna Rd. Hagerstown, MD 21742 Vickie L. Barron-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park 11-3-2012 Hagerstown, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Touglas A. Fiery Funeral Home 21. Signature of Funeral Service License 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MOCOMOIAL INFAMCTION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SINGRE ANGMIA Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence of Examin CONGESTIVE Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical METKBOLIC requires that the death certificate be ACINOSTS P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ LEUCO CTTOSI Division of Vital Records, 1 Yes 2 No 3 Probably 4 Toknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a, Was an has autopsy page 2 Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely

State

29b. Signature and title

certifie

A47916

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number

00062006

combus.

29d, Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 6:00 p M Dona1d Stevens Oct. 30 Joseph Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Golden Living Center Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours **Director** 220-09-9007 1 X M 2 - F 94 03/11/1918 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Washington Hagerstown 10e. Street and Number ō 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 11456 Englewood Road 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner ō þ 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 han "natural", e Medical Exan 1 ☐ Yes 2X No Specify. Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) r than ". Elementary/Secondary (0-12) College (1-4 or 5+) Sheet Metal Worker Manufacturing of Health and Mental Hygie item 27 is marked other other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Washington Stevens Hazel L. Rudisill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health a t: If item 27 is or other train 11456 Englewood Rd., Hagerstown, Maryland 21740 Sharon Seal / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 11/03/2012 Rest Haven Cemetery Hagerstown, Maryland 21. Signature of Funeral Service Linensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complete ions that caused shock, or heart failure. List only one gause on each line ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nterval Between Immediate Cause (Final Onset and Death Physician/ Dron disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence or). physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform Hospital or Attending Physician; The 24 hours after death.

Funeral Director: After this certificate 1 Yes Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No the 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the F To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C g al ns HE RID WV MO 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 30 2012 Joseph Bussy Spillman 7:03 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown 19645 Spring Creek Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral Director** 216-18-8213 88 1 XM 2 □ F Feb. 5,1924 Maryland or 28a-f show notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🛚 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ "natural", or items 23a or edical Examiner must be i Funeral 19645 Spring Creek Rd. 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 42 If Yes, Give 1942 -Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Completed 3 Widowed 4 Divorced Year or Dates. the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Slaes Manager Chemical Co. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Spillman Harriett Bussy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bernice B. Spillman-wife 19645 Spring Creek Rd. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Kurial 2 Cremation 3 Removal from State Rest Haven Cemetery 11-3-2012 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on the use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pars Medical Due (or as a consequence Examiner Sequentially list conditions. Examine One to (presia consequence of) cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trar and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death 2 🗌 No signed by the a 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 has autopsy performed this certificate 1 Yes 2 No 1 Yes 2 🗗 24 hours after death.

Funeral Director; After this certifical letely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 \(\sum \) Yes 28d. Describe how injury occurred Certificate: 5 Pending Investigation 1 Natural injury Accident
Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Vithin 2 3 29b. Sign ture and title of certifier 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) TAI Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8 State FH May Jand / Berard For Health and Mental Hygiene

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	_		Registrar 1. Decedent's Name (First, Middle, I	Last)		Jerum	cate of D	Catri		2. Date of De	Reg. No.	2012	3. Time of Death		
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and the same	Examin		4a. Facility Name (if not institution, g				City, Town, or l		f Death	4c. County of Death					
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	Funeral Director		219-56-9516	. Sex 7. Age	ln yrs. last birthd 61 Yr	Mo	nths Days	Hours	Min.	8. Date of Bir (Month, Da	ay, Year)	9. Bir Co	rthplace (State or Foreign buntry)		
-			Usual Residence of Decedent		01 17	S.				02/92/	1951	Ma	ryland		
	yland f sho	tor	10a. State 10b. County		10c. City, Town o		n						10d. Inside City Limits		
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	ems c	nne	624 Trafalgar I	12. Was Decedent E	ver in U.S.	13. Was I	Decedent of His		in? (Spe	cify Yes or No	_	4. Race - Ame	erican Indian.		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	1	If Yes	, specify Cuban Yes 2 ☒ No	, Mexican	, Puerto F	Rican, etc.)		Black, Whit			
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ary	should and N is ma		19a. Informant's Name/Relationship		19b. N	Mailing Ac	dress (Street ar	nd Numbe	r or Rurai	Rural Route Number, City or Town, State, Zip Code)					
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Baltimore,	ge 1 a it of H : If ite or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3	☐ Removal from State	20b. Place of D cemetery,	Disposition cremator	n (Name of ry or other place			ate	20c. Loc	ation - City or	r Town, State		
Ē	it. Pa		4 Donation 5 Other (Special Country)		Rest H		Cemete me and Address			1/12	Hage	rstown	, Maryland		
Ba	Depa Impo any i		21. Signature of Funeral Service Lic	any					mapel MD 21742						
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	cate be executed physiclan and s the burial-transi	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of)	:									
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	tificate ng ph	Med	IF FEMALE:												
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Ö.	the de	Physician/M	1 Yes 2 No 9 Unknown	9 Unknown	une or death	3 🗆 🔾 11	ici (specify)								
s, P.O	s tha	by	Part II. Other significant condition	s contributing to death bu	ut not resulting in t	the under	tying cause give	en in Part i					o the cause of death? Probably 4 Unknown		
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<u>a</u>	lan: T rtifica ctor, p	Be C	25. Was case referred to medical examiner?	150			26. Pla	ce of Deat	th (Check	1 ∐ Yes only one)	2 X No	T L Te	s Z 🗆 NO		
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Sio	I or Attending Physiclan: The lafter death. Director: After this certificate han by the funeral director, page	27. Manner of Death 1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28b. Time of injury at work? 1 Yes 2 No 28d. Describe how injury occurred									ıral Route Number				
Division of Vital	al or / s after il Dire ed in t											, and produce produce of			
	To the Hospital or Attending Physiclan: The law within 24 hours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2 ompletely filled in by the funeral director, page 2	Medical	(Check 2 Medical Exa	hysician: To the best of a miner: On the basis of ex	amination and/or i	nvestigation	on, in my opinior	n, death oc	curred at	the time, date	and place, a	and due to the	cause(s) and manner stated.		
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المال	J-7		31. Date filed (Month, Day, Year)	MD, 5/6	rail	<u> </u>	ve,	rre	de	CCK	M	DS	1702		
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Carroll Eugene	Sch	1- For State	aryland / Department <i>Certificate</i>	of Health and Mental F of Death			2 3707
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Medical Exami	iner	Carroll Euger			Month Da October 20, 2		1406 hrs
		4a. Facility Name (if not institution, give street 8052 Pushaw Station Road	and number)	4b. City, Town, or Location of Deat Owings	h	4c. County of Death Calvert	
Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday			MM/DD/YYYY) 9, Birt Foreign	
Director		578-50-6676 1X M 2	□F 73	Yrs. Months Days Hours Mir	09/28/19)39 Col	ⁱⁿ Maryland
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
*	ō	MD Calvert	Chesa	peake Beach			1 Yes 2 No
e Mary	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	try?
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212 ould be d Ment s mark	To B	19a. Informant's Name/Relationship (Type, Pri	nt) 19b. Ma	iling Address (Street and Number or	Rural Route Number	, City or Town, State,	lartnett Zip Code)
MD and 2 sho		Bessie N. Schmidt, w		Box 938, Chesape			=
Baltimore, permit. Pages I an Department of Hea Important: If ite		1 Burial 2 X Cremation 3 Ren	noval from State crematory o	r other place)		oc. Location - City or T	,
Iltim nit. Pa artmen cortant	-	4 Donation 5 Other Specify: 21 Sunature of Funeral Service (1007) ee		litan Cremator∳ 10 2.Name and Address of Facility Ra		lexandria,	
Balti permit. Departu Import injury		Buyan 1 Nel	back	8325 Mt. Harmony	Lane, Owi		P.A. 20736
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		Sequentially list conditions,	tensive Atherescleretic Ca	rdiovascular Disease			
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red Insit	Exar	events resulting in death) Last Due to (or as a consequence of):				
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Box 68760, e death certificate by the attending physic ed for use as the but	cian	past 12 months?	Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pregna Other (Specify)	ancy	Month Da	ay Year
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Vital Rec ysician: The l his certificate director, page	S B	25. Was case referred to medical examiner?		26.Place of Death (Check		110	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the fineral director, page 2 should be detach	유	1 ✓ Yes 2 No	1 Inpatient 2 ER/Outpati Date of Injury 28b, Time		g Home 5 Res	idence 6 Other:	Scene
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Visic or Atto fler des Directo	ifica	2 Accident investigation	0-20-12 12:30 e. Place of Injury - At home, farm, s			t capsized	
Divisior Hospital or Attene 24 hours after death Funeral Director:	Ser	4 Homicide determined (S	oecify) Fishing Cree	k Lake	Rd. Owing	gs,MD.	al Route Number, City nw Station
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner on the	basis of examination and/or investi	ccurred at the time, date and place, and igation, in my opinion, death occurred a			
To the within To the comple	Med	and ma	nner stated.	29c. License number		d. Date signed (Mont	
		- ////		O.C.M.E.	0	ctober 21, 2012	
RW 3+1	1	30. Name and address of person with complete Mary G. Rimple MD. Deputy C		00 W. Baltimore Street, Baltir	nore MD 21223	3	
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State Registrar

DHMH 17 Rev 1/2001 OCME 2006

			For State State Registrar	of Maryland		artment of F tificate of E		lental Hygie Reg.	1016	37080	
Ė	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death	
	Medic Examin	al	Margaret Ann Stok 4a. Facility Name (if not institution, give street and r			4h City Town or	Location of Death	10	21 20	2 05-06 AM	
nagel	LXAIIII	GI	Calvert Memorial Hosp			Prince Frederick			4c. County of Death Calvert		
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. E	irthplace (State or Foreign country)	
_			216−38−5997 1 ☐ M 2 💢 Usual Residence of Decedent	70	Yrs.			12/12/194	41 Ma:	ryland	
	ryland -f sho ied at	ctor	10a. State 10b. County	10c. City,	Town or Loc					10d. Inside City Limits	
	he Mar or 28a or potifi	Director	MD Calvert		Hu	ntingtowr 10f. Zip Code	1	100	Citizen of What (1 🗆 Yes 2 🔀 No	
	with t	Funeral	221 Llewelyn Lane			2063	19	l log.	0g. Citizen of What Country? U.S.A.		
	r item		Armed	ecedent Ever in U.S. Forces?	ver in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					nerican Indian, ite, etc.	
036	s after ral", o Exam	ed by	1 ☐ Never Married 2 💢 Married 1 ☐ Ye If Yes, Year or	es 2 X No Give Dates.	1 ☐ Yes 2 🔀 No Specify:					white	
5-0	2 hour "natu edical	plet	15. Decedent's Education (Specify only highest grade complete	ed)		lent's Usual Occupa	ation uring most of worki	ng 16t	o. Kind of Busines		
121	ithin 7 iene. r than	Completed	Elementary/Secondary (0-12) College	(1-4 or 5+)	life. DO	NOT use retired)			own he	nme	
pu	filed wall Hyg	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Maid			
ryla	uld be d Ment marke natic (2	Charles Henry	Tetlow			Margare			ayne	
\mathbf{Z}	12 sho alth and 27 is I		19a. Informant's Name/Relationship (Type, Print) Fenton L. Stokes, hush	and				l Route Number, City			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from	20b. Pla	ace of Dispos	sition (Name of	e) [Date 200	Location - City		
ţ	t. Page rtment rtant: I		4 ☐ Donation 5 ☐ Other (Specify)	Met	ropoli	tan Crema	atory 10/		lexandri	·	
Bal	permi Depai Impo any ir		21. Signature of Funeral Service Licensee	eloceet	ر ا ا ا	Name and Addres Mt. H	s of Facility Rau Larmony La	ısch Funer ane, Owing	ral Home gs, MD 2	, P.A. 20736	
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Box 68760	eath ce attend d for us	ician	in the past 12 months?	outcome of pregnan ve Birth 2 Fetal regnant at time of de	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of o Month	lelivery Day Year	
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Rec	rsician: The law r s certificate has b director, page 2 s	Com						autopsy performed 1 \(\sum \) Yes 2.	death's	es 2 🗆 No	
ita	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:			Loui	ace of Death (Check				
of V	g Physer this	te: To	27. Manner of Death 28a. Da	XInpatient 2 ☐ E te of injury onth, Day, Year)	28b. Time of	t 3 □ DOA 28c. Injury	4 □ Nursing Ho	me 5 Residence 28d. Describe how in		ecify)	
on	tendin leath. or: Aft the ful	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	onin, Day, Tear)	injury	M 1 🗆	Yes 2 No				
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٢	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prhysician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier Check Che	pasis of examination	and/or invest	igation, în my opinio	n, death occurred at	the time, date and pl	ace, and due to the	e cause(s) and manner stated.	
	To the within To the comple		only one) 3 ☐ Certifying Nurse Practition 29b. Signature and title of certifier		-	29c. License			buse(s) and manner Date signed (Mor		
			> NShah/1388				072608	5	10/22/	2012	
1	RW 6		30. Name and address of person who completed confirmed the NIMIT Shah 100 Hospit	tal Road	23a) (Type, P	rint)	erick N	ID 206	18		
V	Stat		Nimit Shah 100 Hospi 31. Date filed (Month, Day, Year) OCT 23 2015	. Registra s Signatu	re A	1	1011/11				
	Registra	ir	ULI 63 /11/	Leneur	A.	parket					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ 0735M October 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Social Security Number | 6. Sex 17 Acraing Ctr. Examiner Wicomico Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 217-28-2977 Director 1 M 2 DXF 98 Maryland Oct. 17, 1914 r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County within 72 hours after death with the Maryland Director Salisbury 1 ∑Yes 2 ☐ No Wicomico MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 21804 200 Civic Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black and Mental Hygiene, is marked other than "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Food Service Serving Federalsburg Sr. Ctr Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fi of Health and Mental fitem 27 is marked ၉ Mattie Kimball Arthur Stephens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carolyn Cooper -- Granddaughter 121 Carolyn Ave., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State permit, Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Federalsburg, MD Federal Hill Cemetery 10/27/12 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 2. Name and Address of Facility Framptom Funeral Home, 1 216 N. Main St., Federalsburg, MD 21632 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying (or as a consequence of): 6M Examin Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical lizabeth Stantord IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death cate has been signed by the a page 2 should be detached Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autop-performed 2 = To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director After this certificate I completely filled in by the funeral director, pag N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c License number address of person cause of death (Item 23a) (Type, Print)

OHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Yea

ignature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 17, 2012 Teresa Ann Shirley 7:11 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Caroline 1140 Osprey Lane Denton Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Months Hours May 25, Year 955 Kentucky **Director** <u>404-82-5</u>469 should be filed within 72 hours are... and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show arke other than "natural", or items 25a or 28a-f show marke event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Denton Maryland Caroline 10g, Citizen of What Country? USA 10e. Street and Number 10f. Zip Code Funeral 21629 1140 Osprey Lane 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 ☐**X**No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed white Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Dispatcher Maryland Park Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mary Rose Briscoe Robert Lee Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1140 Osprey Lane Denton, Maryland 21629 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1140 Osprey Lane Richard Shirley, Sr./spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Queenstown, Maryland St. Peter's Cemetery 10/20/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Moore Funeral Home, P.A. 22. Name and Address of Facility Denton, Maryland 21629 12 South 2nd Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ alunouary disease or condition resulting in death) uller Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to or as a consultience of Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Year Pregnant at time of death 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by ugs tive fleast Failure 1 🗌 Yes Completed 2 No 3 Probably 4 Unknown lletes elizanic origraine 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 3
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

State Registrar 115 Center Way

20770

Greenbelt, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. David Granite

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOWENBER Yea Gerald Reichard TAYLOR, SR. P. M 8:15 012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Boonsboro Reeders Memorial Home If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday, **Funeral** Year) 938 Aug. 19 Hours Min. 1 ℃ M 2 □ F 74 Maryland 214-34-0914 Director Usual Residence of Decedent shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State the Maryland Director or 28a-f sh notified a 1 Yes 2x No Maryland Washington Clear Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ral", or items 23a o Examiner must be Completed by Funeral 21722 U.S.A. Page 1 and 2 should be filed within 72 hours after death with 13902 Dry Run Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes Yes, Give 2 🔀 No 21215-0036 white 1 Yes 2 X No "natural" 3 X Widowed 4 Divorced Year or Dates marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. concrete Block 11 0 truck driver Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once. ည Howard Reichard Taylor Margaret Irene Houser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12121 Heather Drive, Hagerstown, Maryland 21740 Ruth Lushbaugh - Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State November 7,2012 Rose Hill Cemetery Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Euneral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PROBABLE Physician/ MYOCARDIM 25 min disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ARDIONULUPIATIFY MONTH Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral injector, page 2 should be detached for use as the burial-transit MONTH ORONMY that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 🎾 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28h Time of 28d. Describe how injury occurred Certificate: M Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State

29b. Signature and title of certifier

th, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0711

ロのスタリン

AYLOR

Registrar

29d. Date signed (Month, Day, Year)

APPANS ROAD, BOONS 30RO, MARYLAND 21713

Nov. 05. 2012 31-432-8470

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas 1440 10 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Heartland Healthcare Center Hyattsville Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours **Director** 224-48-0219 1 X M 2 🗆 F 75 Usual Residence of Dece 06/10/1937 VA 28a-f show should be filed within recovery and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-1 5...
7 is marked other than "natural", or items 23a or 28a-1 5...
7 is marked other than "natural", or items 23a or 28a-1 5... 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Hyattsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6500 Riggs Road 20783 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **GSA** Maintenance Employee Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Isaiah Thomas Alberta Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Thomas/Brother 11700 Decesaris Blvd. Mitchellville, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 X Removal from State Hampton Memorial 4 Donation 5 Other (Specify) 10/27/2012 Hampton, VA 21. Signature of Funeral Service in nsee 22. Name and Address of Facility Marshall-March Funeral Home It 1. Enter the disease, or complications that caused the heath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 4217 9th St. NW Washington, DC 20011 shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a con equence of) sician and burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of Be Completed by Physician/Medical Box 68760 the SB JE FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Year 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an 24b. Were autopsy findings available the Hospital or Attending Physician: The law prior to completion of cause of death?

1 Yes 2 No autopsy Disease the funeral director Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ရ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director, After 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 \square Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely fi 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of certifier

Registrar

State

31. Date fled (Month, Day, Year)

NOV 01 2012

4701 Fandolph Pd # 216. Reckville, MD 20852.

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydienes

			For State Registrar	State of Maryland		artment of F tificate of L		d Mental Hy	Reg. No.	2 37085
	Physicia	n/	1. Decedent's Name (First, Middle, Last Lincoln William					2. Date of De	eath Day Yea	3. Time of Death
-	Medic Examin		4a. Facility Name (if not institution, give s	street and number)		4b. City, Town, or			4c. County of D	
المود	Funeral		Renaissance Gardens 5. Social Security Number 6. Sec			e Silv	er Spri		P.G.	Birthplace (State or Foreign
	Director		470-28-2845 Usual Residence of Decedent	Дм 2 □ ғ 82	Yrs.	Months Days	Hours	Min. (Month, Da	ay, Year)	Country)
	/land f show ed at	tor	10a. State 10b. County	10c. City	, Town or Lo	cation		June 24	2, 1930 P	10d. Inside City Limits
	r 28a- r notifie	Direc	MD Montgon 10e. Street and Number	ery Silv	er Spr	ing 10f. Zip Code			40 000 1110	1 Yes 2 No
	with th	Funeral Director	3112 Gracefield R	oad, Apt. 221		20904	4		10g. Citizen of What USA	Country?
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1¾ Yes 2 □ No If Yes, Give Year or Dates. 1952—	1	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	14. Race - A Black, W Specify: Wh	
21215-0036	ithin 72 hou ene. • than "nat he Medica	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give I life. D	dent's Usual Occup. kind of work done of O NOT use retired) tems Ana	luring most of	working	16b. Kind of Busine	
nd 2	filed w tal Hygi ed other event, t	To Be	17. Father's Name (First, Middle, Last)	4	bys	tems Ana.	18. Mother's	Name (First, Middle,	Maiden Surname)	Affairs
Maryland	ould be nd Men marke imatic		John Edgar Talbot 19a. Informant's Name/Relationship (Type)		19b Mailin	ng Addraes (Street		fred Wint	er, City or Town, State,	Zin Codel
	nd 2 sh ealth ar m 27 is er trau		Benita JOnquil Tal		1					ing, MD 20904
Baltimore,	. Page 1 a ment of H tant: If ite jury or oth		20a. Method of Disposition 1 ☐ Burial 2★★Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	emetery, cren	sition (Name of natory or other plac tan Crema		Oct. 31, 2012	20c. Location - City Alexandri	
Ball	permit Depart Impor any in once.		21. Signature of Funeral Service License	& MO150;	3 Fr.	Name and Address ancis J. Univers	s of Facility Collin	s Funeral	Home Inc.	no. MD 20901
			23a. Rant 1. Enter the disease, or compl shock, or heart failure. List only on Immediate Cause (Final	ications that caused the death e cause on each line.						Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	a. Alzheimer's I Due to (or as a conseque		e				unknown
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	ence of):					
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	0.						9.0
209	ficate be executed g physician and as the buring transit	edical E	resulting in death) Last	Due to (or as a consequent	ence or):					
6876	ertificat ding ph se as th		IF FEMALE:	3c. If yes, outcome of pregnan	nev					
). Box 68	 Hospital or Attending Physician: The law requires that the death certifit 24 hours after death. Funeral Director: After this certificate has been signed by the attending etely filled in by the funeral director, page 2 should be detached for use as 	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 2 Fetal 4 Pregnant at time of do 9 Unknown	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	delivery Day Year
s, P.O.	requires that the dea been signed by the s should be detached	ğ	Part II. Other significant conditions con Atrial Fibrillati			, ,				to the cause of death? Probably 4 🔀 Unknown
Records,	w requi s been 2 shouth	Completed					arey Di	24a. Was	an 24b. Were	autopsy findings available
Rec	nysician: The law inis certificate has t							auto perfo 1 🗆 Yes	ormed? death	to completion of cause of 1? Yes 2 No
Vita	ysician s certifi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ KNo	lospital:	FB/Outpatien	Othe	ar.	Check only one)	dence 6 🗆 Other (S)	nacify)
Division of Vital	tending Physeath. tor: After thi the funeral	Certificate: 7	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ AccidentInvestigation		28b. Time of injury	28c. Injury work	at	28d. Describe h	now injury occurred	echy)
Divisi	tal or Atter rs after de al Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,
	To the Hospital or ν within 24 hours after To the Funeral Dire completely filled in t	Medical	(Check 2 Medical Examin	cian: To the best of my knowle er: On the basis of examination Practitioner: To the best of m	and/or invest	igation in my opinio	n death occur	red at the time date a	and place, and due to the	ne cause(s) and manner stated
	12+1		29b. Signature and title of certifier	malor	RAJF	29c. License		67	29d. Date signed (Mo	
			30. Name and address of person woo co Eileen Gemmell, CF	mpleted cause of death (Item : RNP 3160 Gra	23a) (Type, P cefiel	rint)	Silver	Spring, N	4D 20904	
	Stat Registra	_	31. Date filed (Month, Day, Year) NOV 01 2012	32. Registrar's Signatu	ire par	W.				

			For	State of Ma	ryland / De	partment of	Health and	Mental Hy	giene	27006
		_	State Registrar		C	ertificate of	Death		Reg. No 20 2	37085
	Physicia Medic		1. Decedent's Name (First, Middle, La	3HALL	THO	MAS		2. Date of De Month	22 ^{Day} 2012	3. Time of Death
	Examin	er	4a. Facility Name (if not institution, giv.	e street and number) L GARI	DENS	4b. City, Town,	or Location of Deat	h	4c. County of Dea	SOT
	Funeral Director			Sex 7. Age ((In yrs. last birthda) Yrs.	Months Day		(Month, Da		ountry)
	aryland a-f show fied at	ctor	Usual Residence of Decedent 10a. State 10b. County	\rac{1}{1}	10c. City, Town or EAST			101		10d. Inside City Limits 1 ☑ Yes 2 ☑ No
	ith the Ma 23a or 28a st be noti	Funeral Director	10e. Street and Number 709 ELWOOL	AVE	21010	10f. Zip Code	201	_	10g. Citizen of What C	
	r death w or items ? niner mus	by Fune	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Even Armed Forces?			Hispanic Origin? (Suban, Mexican, Puerl		14. Race - Am Black, Whi	
-0036	nours afte latural", o ical Exan	eted b	3 ₩idowed 4 □ Divorced	If Yes, Give Year or Dates.		1 Yes 2 1			Specify: L	JHITE s/Industry
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4 or 5+)	(Gir	re kind of work don DO NOT use retire SECR I	e during most of wo	rking		ICAL
Maryland	ld be filed Mental Hyg arked oth atic event	To Be	17. Father's Name (First, Middle, Last) HARTMAN		HALL		18. Mother's Na	me (First, Middle	Maiden Surname)	
Man	2 should h and M 1 7 is mar traumat	1	19a. Informant's Name/Relationship (/ 1	ural Route Numb	er, City or Town, State, Z	(ip Code)
			20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other p	JUON C	Date	20c. Location - City of	or Town, State
Baltimore,	t. Page tment tant: I ijury o		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	rify)	HILLER	LEST CEM	ETERY "	126/12	FEDERAL	SBURG, MO
Ba	permit Depar Impor any in	9	21. Signature of Funeral Service Licer			22. Name and Add WILLIAMS 311 S. MA	IN ST. A	ENERAL H	OME SBURG, M	D Z1632
	Ffeysicism/	i i	23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused to one cause on each line.	he death. Do not e	nter the mode of d	ying, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a of	consequence of):	e to	Thrive			
	d sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Lines Underlying	b	consequence of):			41		
	ate be executed hysician and the burial-transit	ıl Exar	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):	osi's c	myleap	eathy		
760	cate be physici s the bu	edical		■ d						
Box 687	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	Fetal death	B Ctopic pregnation of the Control o			23d. Date of d Month	elivery Day Year
, P.O.	es that the signed by		Part II. Other significant conditions		t not resulting in th	e underlying cause	given in Part I.		tobacco use contribute	to the cause of death?
ords	tw requir as been s 2 should	Completed by	Atrial Fibrilla Hypertension					24a. Was	an 24b. Were a	autopsy findings available completion of cause of
l Rec	sician: The law certificate has b lirector, page 2 s		25. Was case referred to medical	1		00	DI 15 11 (0)	perf 1 \(\sum \) Yes	ormed? death?	es 2 🗆 No
Vita	ysician: is certifica director,	To Be	examiner?	Hospital:	nt 2 🗆 ER/Outpa	- 10	Place of Death (Che		idence 6 3 0ther (Spe	ecity) Asst LVing
Division of Vital Records,	tending Phys leath. :or: After this the funeral di		27. Manner of Death 1-★ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day,	28b. Time	of 28c. In			how injury occurred	7
Division	al or Atte s after des il Directol ed in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		y - At home, farm, (Specify)	street, factory, offic	е		Street and Number or R wn, State)	ural Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical	(Check 2 Medical Exan	ysician: To the best of m niner: On the basis of exa rse Practitioner: To the l	amination and/or inv	estigation, in my op	inion, death occurred	at the time, date	and place, and due to the	e cause(s) and manner stated.
	To t With To tl		29b. Signature and title of certifier	116			nse number		29d. Date signed (Mon	
			30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type	e, Print)				
	Stat Registra	e	Kystal L Thomas 31. Date filed (Month, Day, Year) OCT 2	32. Registrar	's Signature	Marie Di	IVE LI	ns on,	J 270	
					,	· #				

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death TSAIN WI Physician/ WIN Month ODPM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death mo olumbia If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) China 7. Age (In yrs. last birthday **Funeral** 8. Date of Birth Days 1 **№** M 2 🗆 F 4-19200 569-48-1312 92 **Director** Usual Residence of Decedent 28a-f show 10a, State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Columbia 1 Yes 2 XNo MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5129 Darvel Circle 21044 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Divorced 4 Divorced Year or Dates Asian 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Medical Medical Doctor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a 1433 Kingstream DriveHerdon, VA 20170 Michael Bernard Wei/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10-29-12 Hanover, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 Lanua 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of attending physician for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has perforn certificate 2 No Yes 2 No 1 Yes Division of Vital the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 Tes 2 No မူ 1 Nonpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10/26/2012 Michael A. Williams 2045 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours 214-66-6680 Country. **Director** 56 04/19/1956 f show within 72 hours after death with the Maryland r then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Directo MD Montgomery Silver Spring 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12325 New Hampshire Avenue 20904 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Black, White, etc. δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hyglene. Important: If item 27 is marked other then eny injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Cashier Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy Hickman Mary Helen Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Morrison/brother 1487 Eden Drive, Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 11/01/2012 Hanover, MD mation Ctr of MD Signatur f Funeral Service 22. Name and Address of Facility Snowden Funeral Home un 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death WEEKS Immediate Cause (Final Physician/ Respiratory failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pneumonia weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buring regasting. ause (Disease or injury signed by the attending physician and defeathed for use as the buring states Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Chronic kidney disease, stage IV 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 XNo မ 1 X Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 ta D32332 10/28/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gupta, MD 9801 Georgia Avenue, #220, Silver Spring, MD 20902 Suresh K. 31. Date filed (Month, Day, Year) NOV 01 2012 Registrar

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		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death
		316 Lanafield Circle	Boonsboro		Washington
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 577-46-6601	Months Days Hours M	lin	(MM/DD/YYYY) 9. Birthplace (State or Foreign
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a nr 28a-f sho injury nr other traumatic event, the Medical Examiner must be notified at once.	^L		ling Address (Street and Number of		
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Baltimore, permit. Pages I and Department of Heal impurtant: If iten		1 Burial 2 X Cremation 3 Removal from State crematory or	other place)		•
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Box 68760, c death certificate be exthe attending physician of for use as the burial	W.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregr	nancy	23d. Date of delivery Month Day Year
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n of ading Ph	<u>ë</u>	27. Manner of Death 1 Natural 5 Pending FOUND: Pay, Year) Pending FOUND: Day, Year) 1 Natural 5 Pending FOUND: Pound Pay Not Pending	of Injury 28c. Injury at Work? 1 Yes 2 ✓ No	Subject fell of	w injury occuπed ff ladder
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Division Rospital nr Attend 24 hours after death Funeral Director:	Certification:	Suicide 6 Could not be determined (Specify) Townhouse / Rowho		or Town, Sta	
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To the within 7 To the complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investion and manner stated.	1		
0	~	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) October 28, 2012
20		30. Name and address of person who completed cause of death (Ifem 23a)	0.0.11.12.		0.00001 20, 2012
12/4	4	Zabiullah Ali, M.D. Assistant Medical Examiner 900 W.	Baltimore Street, Baltimore	, MD 21223	
		31. Date filed (Month, Day, Year) 32. R (gistrar's Signature)	and the		
Regist	rar	OUT S & COLE			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 2012 330 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Boltmore TRADELICK Uilla NSG RUS Dellas Chris 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs Davs Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 218058693 **Director** 1 XM 2 □ F 90 922 06 1 Usual Residence of Decedent vland ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Baltimore City Md Baltimore 10f. Zip Code 10g. Citizen of What Country? Funeral 514 Old Orchard Road 21229 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 X Yes 2 □ No
If Yes, Give Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural" Completed 3 Widowed 4 Divorced Specify: Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Minister/Pastor other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Wayman Williams, Sr Niomi Irene Gale 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is n any injury or other to once 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 514 Old Orchard Rd., Baltimore, Md. 21229 Viola Moore /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Md. Veterans Cem 10-26-12 Hurlock, Maryland 21. Signature of Eugeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover St., Easton, Maryland 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician. disease or condition resulting in death) 300 W 4 Medical consequence of **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year signed by the at d be detached for 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗆 Yes 2 🗆 No 3 🗔 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospita Other: 1 Tyes P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 ☐ Residence 6 ☐ Other (Specify, funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work?
1 \sum Yes 2 \sum No 5 Pending s after death. Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Taymer & Mills Da7683 22/12 10 NS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Raymond Mille

31. Date filed (Month, Day, Year)

UCT 24

Box

1525

32. Registrar's Signature

DWID

Mills

MD

			State of Maryland	-				9.0	12 37091				
		7	State Registrar	Cen	tificate of D	eath		Reg. No. 2 U					
	Physicia	_	1. Decedent's Name (First, Middle, Last) Florence Wolfe				2. Date of Dea Month	Day	Year 2355 PM				
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	ocation of Death	70	4c. County					
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	Birthplace (State or Foreign Country)				
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(0	er dea or iter niner	y Fu	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	If	Yes, specify Cubar	, Mexican, Puerto	Rican, etc.)		ck, White, etc.				
99	rs aft	Completed by	3 👿 Widowed 4 □ Divorced If Yes, Give Year or Dates.	1	Yes 2 X No	Specify:		Specify	White				
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nor	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heatht and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 N Burial 2 Cremation 3 Removal from State	netery, cren	enorial Par	9)	1	Rockvil	lle, MD				
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Box	death	sicia	In the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of de		Other (specify)	,		M	onth Day Year				
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practitioner: To the best of my	and/or inves	tigation, in my opinio	on, death occurred a	it the time, date a	and piace, and di	ue to the cause(s) and manner stated.				
	To the within To the Somple	Σ	only one) 3 \(\subseteq \text{Certifying Nurse Practitioner: To the best of m}\) 29b. Signature and title of certifier	y kuowieage	29c. License	number		29d. Date signe	ed (Month, Day, Year)				
			1	7	D	206178	5	10-1	18-2012				
-			30. Name and address of person who completed cause of death (Item	23a) (Type, I	Print) Print	e Frede	erick.	mo	20078				
	Sta Registr		31. Date filed (Month), Day, Year) 32. Registrar's Signatu	parke	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1520 M Month 2012 Florence Helen Reed Walls Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Easton Memoria Hospital Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Days Hours Country) 222-05-7618 Director 1 □ M 2 🗓 F Jan 15 1923 Delaware or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2X No Maryland Queen Anne Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21617 716 Roe-Ingleside 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. 2 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Completed 3 X Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health end Mentel Hygiene. Important: If item 27 Is marked other than 'any Injury or other traumatic event, the Mis Elementary/Secondary (0-12) College (1-4 or 5+) own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Addie Morris George Louis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21617 716 Roe-Ingleside Road; Centreville, Maryland Kay Nickolson/ daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Church Hill Cemetery Oct 26 2012 Church Hill, Maryland any Injury once, 4 Donation 5 Other (Specify) 22. Name and Address of Facility PO Box 160; Greensboro, MD Signature of Funeral Service Licenses Fleegle and Helfenbein Funeral Home, PA 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysiclan/ disease or condition resulting in death) Medical Due to (or Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Exami been signed by the attending physicien and should be detached for use es the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ a I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 1 Tes 24a. Was an 24b. Were autopsy findings available s certificate has b director, pege 2 s autopsy prior to completion of cause of death? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Division of Vital 25. Was case referred to per ical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) |@ 1 🗌 Yes 2 1 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Mann Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who com Ludwig Eglseder, III MD 503 Cynwood Drive; Easton, MD 21601

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

32. R

OCT 26 2017

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No./ Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Christine Wimert Month 303 2ďľ2 9:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospice Dove House Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth Days Hours Min (Month, Day, Year) 174-36-5122 Director 1 □ M 2 🕅 F 68 PA 12/23/1943 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 938 Leisters Church Road 21157 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married à within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hyglene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) daycare provider own home e 1 and 2 should be filed with of Health and Mental Hyglen If item 27 Is marked other th or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Ryan Everett Blevins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157 938 Leisters Church Road, Westminster, MD James Wimert/husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any Injury or ott Date 20c. Location - City or Town, State cemetery, crematory or other place
St. John Leisters 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/02/2012 Westminster, MD 22. Name and Address of Fatheritts Funeral Home and Signature of Funeral Service Licensee Chapel, K 21157 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that causes, the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Liter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burlal-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autonsy 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? NPIMBA Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital: 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Jugs 1 Certificate: 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature title of certifier 29d. Date signed (Month, Day, Yea rşon who go Print) State Registrar

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Physician	/						Month	Day 08		3. Time of Death
Medica Examine		Eileen A. Wardak 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	r Location of	f Death			. County of Dea	6:00 PM ^M
		1105 Mill Creek Road		FAllsto					Harford	
Funeral		5. Social Security Number 6. Sex 7. Age (In yr.	s. last birthday)	If Under 1 Year Months Days	If Under 2 Hours		8. Date of Bir	th	9. Bi	rthplace (State or Foreign
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and show			City, Town or Lo	cation						10d. Inside City Limits
Maryk 18a-f		MD Harford F	allston							1 ☐ Yes 2X No
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o36	og po	3 Widowed 4 Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2 🗶 No	Specify:				Specify: Wh	nite
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of Healt fitem 2	1		. Place of Dispo				ate		ocation - City o	
Page 1 Page 1 ment of 1 ant: If it		4 □ Donation 5 □ Other (Specify)				1/12	2/2012	Balt	imore,	Maryland
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Examonoe.		21. Signature of Funeral Service Licensee **Europe A H Sas***		Name and Address 1750 Bela		r.				l Home, P.A.
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Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director. Madical Cartificate: To Bo	<u> </u>	29a. Certifier 1 Certifying Physician: To the best of my kno	owledge, death of	occured at the time	, date and pl	lace, and	d due to the ca	use(s) an	d manner as s	tated.
the H nin 24 the Fu		(Check 2 ☐ Medical Examiner: On the basis of examina only one) 3 ☐ Certifying Nurse Practioner: To the best of						e cause(s	and manner a	s stated.
To with	1	29b. Signature and title of certifier		29c. License					te signed (Mon	th, Day, Year)
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(D)		30. Name and address of person who completed cause of death (It		Corporal	t. C.	ا اسلام	715	41:	and in-	11.1 7.006
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Registrar		NOV 1 6 2012	parked							

DHMH 17 Rev 7/2009

Registrar DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 November 1:44 a. Lawrence Reid YOUNG Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington 20447 Kings Crest Blvd <u>Hagers</u>town Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Hours **Director** 1 🗶 M 2 🗆 F 72 509-36-5604 Dec. 12 1939 Kansas Usual Residence of Dece 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified 1 Yes 2X No Maryland Washington Hagerstown 10e. Street and Numbe 0 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 20447 Kings Crest Blvd. USA 21742 items death 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates.

Vietn "natural", or item edical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hyglene. Fart I fee 27 is marked other than "natural", or ury or other traumatic event, the Medical Examinury or other traumatic event, the Medical Examinury. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Vietnam Specify Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Purchasing Agent Lighting Mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Roell Young Rosamund Ila Loree Fowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health
Important: If item 2:
any injury or other t Barbara Young - Wife 20447 Kings Crest Blvd., Hagerstown, Md. 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 11/2/2012 Hagerstown, Maryland Leunera Service Licer 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician. Mumous disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine thoke burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical death certificate be P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death be detached 1 ☐ Yes 2 L 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an e Hospital or Attending Physician: The law 1 24 hours after death. • Funeral Director: After this certificate has t page 2 autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 2 1 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation npletely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one)

2

State Registrar

29b. Signature an

Name and address of p

vho completed cause of death (Item 23a)

32. Registrar's Signature

ar

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible AMEND TTEM#9, 17, 18perFH, G933, 11/26/2012, WS State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Bert Alderman 2012 5:40 p^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Ritchie Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 243-16-3005 North Carolina Director 1 □ M 2X F 95 Yrs 09/02/1917 Teachy, Usual Residence of Decedent al Hygiene. I other then "netural", or items 23e or 28e-f show went, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours efter death with the Merylend Depertment of Health end Mental Hyglene. Importent: If item 27 is marked other then "netural", or items 23e or 28e-f show eny Injury or other treumatic event, the Medical Examiner must be notified at. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 Dyres 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1012 Appleton St. 21217 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Own Home 7th Be 17. Father's Name (First, Middle, Last)

Character Lawrence 18. Mother's Name (First, Middle, Maiden Surname) UNK Callie Lawrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Alderman (Son) 1012 N. Appleton St. Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest 12/3/12 Owings Mills, MD Signature of Funeral Service Licenses Josephin H. Brown, Jr. Funeral Home PA 2140 N. Fulton Ave. Balto., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner nna Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospitel or Attending Physicien: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) The Nuspice 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Mary 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0057644 November 15,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rache Levine 5200 Easten Ave MFLBIdg Snite 2300 Baltimore, MD 21229 31. Date filed (Month, Day, Year) State 32. R NOV 19 2012 rack Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u> 2012</u> 12:38p M PAUL November ALSTON Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2500 W. BELVEDERE AVE. APT 618 BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country 1 M 2 □ F Director 242-40-6020 83 Yrs. 8 1929 NORTH CAROLINA filad within 72 hours.....tel Hygiene. ed other then "naturel" or items 23a or 28a-f show es ovent, the Medical Examinet must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1XXYes 2 □ No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2500 W. BELVEDERE AVE., APT 618 21215 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 🖾 Yes 2 🗌 No Black, White, etc. 1XXNever Married 2 ☐ Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXIIIo Specify: If Yes, Give Year or Dates Completed 3 Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5th grade STEEL WORKER BETHLEHEM STEEL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pege 1 and 2 should be filar Department of Health end Mantel H Important: if Item 27 is marked of any njury or other traumatic ever once. ဂ္ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie Walker/Friend <u> 2214 Bryant Ave., </u> Baltimore, Maryland 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FOREST 11 - 30 - 12OWINGS MILLS, MARYLAND 21. Signature of Funeral Sorving Licens 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE Deellen 23a. Part 1. Priler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ MYOCARDIAL INFARCTION MINUTES Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician end burial-trensit Cause (Disease of Injuly that initiated events resulting in death) Last Due to (or as a consequence of): ŵ physician s the burla Physician/Medical that the deeth certificeta be Box 68760 ettanding p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Pregnant at time of death 5 Other (specify) ad by the e 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signad I 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: Tha lew requires Records, STROKE WITH LEFT HEMIPARESIS, 1997 To the Hospital or Attending Physician: Tha lew requires within 24 hours efter death.

To tha Funeral Director: After this certificeta hes bean signompietely filled in by tha funeral diractor, page 2 should I 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed' 2 1 N 2 🔀 No 1 🗌 Yes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The deficient Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CONRAD MAY M.D. BALTIMORE , BALTIMORE VAMC, 10 N. GREENE ST. 31. Date filed (Month, Day, Year)

Registrar

29c. License number

DOD32186

29d. Date signed (Month, Day, Year)

21101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edward Irving Acree Month. 2012 9:30 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Mospice Dove Mouse Carroll Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8 Date of Birth Funeral Days Hours (Month, Day, Year) 212-36-5670 73 Director 14 M 2 D F Maryland June 25, 1939 Usual Residence of Decedent ir then "neturel", or items 23e or 28e-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Carroll Sykesville 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21784 1210 Canterbury Drive U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify If Yes Gives 7-1961 Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Accounting permit. Pege 1 end 2 should be filed w Department of Health and Mental Hygl Importent: if item 27 is marked othe eny injury or other treumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elizabeth Warfield Irving L. Acree 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1210 Canterbury Dr. Sykesville, MD. 21784 Catherine M. Acree - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
S. Carroll Crematory 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State S. Nov. 20,2012 Sykesville, MD. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Harth 11605 Reisterstown Rd. Owings Mills, MD. 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury Examine Due to (or as a consequence of) ettending physician end I for use es the burial-transit Hospital or Attending Physician: The lew requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death 9 Unknown sate has been signed by the page 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2V No 24 hours after death.

Funerel Director: After this certificate letely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other:
4 Nursing Home 5 Residence 6 Other Specific ဂ္ 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9

01027

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 201^{Yea} Lucy Hernady Arnoti 11:20 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7425 Democracy Blvd. #10 Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours Min. **Director** 066-03-3752 1 □ M 2 🗓 F 100 February 23, 1912 Hungary or 28a-f shov filed within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland Montgomery Bethesda 1 🗌 Yes 2 🏻 No 10e. Street and Number 10g. Citizen of What Country? Funeral 7425 Democracy Blvd. 20817 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🌠 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. 3 N Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) American Cancer 12 Community Health Society Be event, permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: if item 27 is marked oft any injury or other traumetic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Maximilian Goldzicher Margaret Strasser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19930Sharon Korody /Daughter-in-law P.O.Box 637, 38923 Cypress Lake Circle, #56084, Bethany Beach, DE 20a. Method of Disposition 20b. Place of Disposition (Name of Montgoiller) 20c. Location - City or Town, State November 1 D Burial 2 X Cremation 3 D Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 14, 2012 Crematorium, Inc. Signature of Furter Service Licenses 22. Name and Address of Facility. Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 M01305 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysiciani Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or figury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 4 Pregnant 9 Unknown 5 ☐ Other (specify) Day Month Pregnant at time of death n signed by the a lid be detached 1 1 Yes 2 g Part II. **Other significant co**nd**itions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate has been significate has been significated funeral director, page 2 should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🕅 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 Cher (Specify) Hospital: ျှ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.
Funeral Director: After thi etely filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 7. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year) D26259 November 13, 2012 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Ava A. Kaufman, M.D. 8218 Wisconsin Avenue, #103, Bethesda, Maryland 20814 State 32. Registrar's Signature Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ EMILY 8:55 DM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death UNIVERSITY OF MARYLAND MEDICELY BALTIMORE N/A 6. Sex 7. Age (In vrs. last birt If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 191-27-4863 1 □ M 2 🏋 F 26 MD 10/18/2012 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director must be notified MD Montgomery Potomac 1 Yes 2 XNo 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 7723 Fontaine Street 20854 U.S.A. items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Examiner Black, White, etc. o þ 1X Never Married 2 ☐ Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: Caucasion "natural" 3 Divorced 4 Divorced Completed Year or Dates Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) N/A the N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers မ Jonathan R. Bloom Ivana Lisavac 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 7723 Fontaine St. Potomac, MD 20854 Jonathan R. Bloom (Father) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 Burial 2 X Cremation 3 Removal from State 11/19/12 Baltimore, MD On-Site 4 Donation 5 Other (Specify) Crematory : of Funeral Service Licenses Joseph H. Brown, Jr. Funeral Home 2140 N. Fulton Ave. Balto., MD 212 21. Signatu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate RESPIRATOR Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? death? certificate 2 No 1 Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manver of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural iniury 5 Pending s after death.

I Director: Aft
ed in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours after Funeral Direct letely filled in b City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Đay, Year) -

DHMH 17 Rev 06-2011

SI

cause of death (Item 23a) (Type, Print)

110

2012

BAUTIMORE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Nonth Nove-Der Physician/ LOIL 0:11 BARR WILLIAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner alt:more 5. Social Security Number Hospito If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** Davs (Month, Day, Year) Director 216-32-0133 1 XX 2 □ F 79 SOUTH CAROLINA MAY 4 1933 show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-1 shount if item 27 is marked other than "natural", or items 23a or 28a-1 shount up or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No BALTIMORE MARYLAND N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21216 2511 ALLENDALE RD. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black. White, etc. 1 X Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) SUN CAB CO. LABORER 8th grade Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ BESSIE WILSON WARREN BARR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2511 Allendale Rd., Baltimore, Maryland 21216 Carrie E. Bell/Sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury or once, 11-26-2012 LANSDOWNE, MARYLAND ZION CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 24. Signature of Juneral service License WILLIAM COBROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Due to (or as a consequence of) disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine hyper tension The law requires that the death certificate be executed certificate has been signed by the attending physicien and irector, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 R/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work?
1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 6610Y 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B-1+1~ 900 Laton 31. Date filed (Month, Day, Year)

State

Registrar

NOV 19

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 November 10:55 AM Loretta Blaney Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Director 214-12-3589 1 □ M 2 🖾 F 94 Vrs Jan 25, 1918 Maryland ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 ☐ Yes 2√☐ No Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7700 Oak Leaf Road 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 11. Marital Status 14. Race - American Indian, Was Deceded Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 1 ☐ Yes 2 🔯 No Specify. Specify: 3 Divorced white Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) housewife own home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, is Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2012 မ Patrick Francis O'Neill Ellen Mary Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 530 E. 84th Street #3 New York, NY 10028 Retta Blaney/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4
☐ Other (Specify) Signature Funeral Service Liceus 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dementa disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): that the death certificate be executed the burial-tran Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 1
 24 hours after death.
 Funeral Director: After this certifica filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

filed (Month, Day, Year) NOV 1 9 2012 Dulaney Valley Rd Timonic

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Geneva Brannon 201 8:30aff Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Baltimore 212 N. Port St. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours 218-22-2716 Director 1 ☐ M 2 🛣 F 84 13,1928 SC Feb Usual Residence of Decedent or 28e-f show 10a State 10b. County the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Md 1 Yes 2 No Baltimore n/c 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 236 Funeral 212 N. 21224 USA Port St. or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. should be filed within 72 hours afte end Mental Hygiene. ie marked other then "naturei", 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HomeMaker Home 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 end 2 should be Department of Heelth end Men Importent: if item 27 ie marke eny injury or other treumetic once. Martha Thompson Samuel Brannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Port St. Baltimore Md 21224 James Brannon/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery Nov. 27, 2012 Baltimore, Md 21. Signature of Funeral Servi Licensee 22. Name and Address of Facility CALVIN BPRESTON STFUNERAL HOME 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cau ie on each line. Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events burial-tran resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical certificate be ミッチ Beeords, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 № 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 21 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 ☐ No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 မှ 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 27. Marmer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funerel Director: After tompletely filled in by the funer 5 🗌 Pending injury Naturai 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one title of certifier 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21093 31. Date filed (Month, Day, Year) 2. Registrar's Signature State NOV 1 9 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Virginia Lee Battle Month 9-35 AM November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 01 Baltimone Sinai Hospital Baltimore
If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 215-58-4872 Director 61 1 □ M X X F June 14,1961 Maryland Page 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health end Mental Hygiene. Fent: If item 27 is marked other then "natural", or items 23a or 28e-f show lury or other treumatic event, the Medical Examiner must be notified at 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2XXNo Baltimore Reisterstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 101 Shetland Circle 21136 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No 21215-0036 1 Yes XXNo Specify: Specify: White 3 Widowed 4X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Lion Brothers Laser Operator 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Francis Cardwell Dorothy Regina Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KImberly D. Parson daughter 22 St. Paul Ave. Reisterstown, MD 21136 20a. Method of Disposition
1 ☐ Burial ※XXCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
South Carroll
Crematory 20c. Location - City or Town, State permit. Page 1 c
Department of F
Importent: If ite
eny injury or oti 4 Donation 5 Other (Specify) 11/19/12 Sykesville, MD 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21. Signature of Funeral Service License 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Advanced Metastatic concer month Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): signed by the ettending physicien and debached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 pronths?
1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Hyper tusia 1 Yes 2 No 3 Probably 4 Unknown Completed 24 hours after death.
Funerel Director: After this certificate has been si etely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe death? 1 ☐ Yes 2 🅻 No Yes 2 😿 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 🗌 No 2 Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and address Uperson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Peistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death Decedent's Name (First Middle, Last) 3. Time of Death November 2 Physician/ 11811 A M Johnnie Mae Blanchard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P.G. Seabrook Doctors Community Hospital 8. Date of Birth (Month, Day, Year) 07/29/1945 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Months Hours Min Director 230589861 67 1 M 2 X F Suffolk, VA 28a-f shov 10d. Inside City Limits 10c. City. Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director MD P.G. Seabrook 1x Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 20706 6803 Storch Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Force þ 1 Never Married 2 Married Yes 2 No 1 Yes 2 No Specify Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 3/enchard Elementary/Secondary (0-12) College (1-4 or 5+) marketing firm marketing specialist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jessie L. Johnson Johnnie Walltower 19a. Informant's Name/Relationship (Type, Print) (spouse) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 6803 Storch Court, Seabrook MD., 20706 Freddie R. Blanchard 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Date Suffolk, VA 11/13/12 Carver Memorial Donation 5 Other (Specify) 420 H ST.NE Signature of Funeral Service Licensee 22. Name and Address of Facility B.K. Henry Funeral Chapel Wash.DC.20002 Nemu art 1. Enter the disease, or complications for caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARRHYTHMIA Physician/ MINUTES disease or condition resulting in death) Medical Examiner MINVITES PULMONARY EMBOLISM Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 No a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, DIABLETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 MER/Outpatient 3 IDOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation after death Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Marken M·D 2012

Registrar

DHMH 17 Rev 06-2011

State

MITCHELVILLE ROAD

3048

BOWIE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATHEU

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31. Date filed (Month, Day, Year)

Wilbert Evern Bo		otato or iviarylana, Bop		Health ar		ygiene	201	2 3710
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle,Last) Wilbert E. Boone				2. Date of Death Month November		3. Time of Death 1025 hrs
		4a. Facility Name (if not institution, give street and number) Harbor Hospital	1	o. City, Town, o	r Location of Death		4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Yes			(MM/DD/YYYY) 9. Bir	hplace (State or
Director		217-74-4027 1XM 2_F 63	Yrs.	Months Day	s Hours Mir	03-21	-49 Foreig	n untry) NC
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City	y, Town or Location	n				10d. Inside City Limits
·land -f show	ğ		Randallst					1 Yes 2 No
	Director	10e Street and Number 8409 Horatio Road		10f. Zip Code 21	133	10(g. Citizen of What Cour USA	ntry?
ith with tems 23	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?			spanic Origin? (S n, Mexican, Puerto		1A/hita ata	can Indian, Black,
fter dea		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 N	res 2 X No	specify: Amen	African cican		
hours a	ed by	15. Decedent's Education (Specify only highest grade completed)			ation (Give kind of b. DO NOT use ret		16b. Kind of Business/I	
036 ithin 72 ne. r than "	Completed	Elementary/Secondary (0-12) Unk. College (1-4 or 5+) NA		isable			Never Wo	cked
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	ဦ	17. Father's Name (First, Middle, Last) Buris Ervine Boon			18.Mother's Name	e (First, Middle, Ma	aiden Surname)	
212 buld be I Menta marke	To Be	19a. Informant's Name/Relationship (Type, Print)		Address (Stre			per, City or Town, State	, Zip Code)
MD and 2 sho	- 1	Janice Boone-Sister 20a. Method of Disposition 120b					e, Marylan	
Baltimore, permit. Pages I ar Department of Hee Important: Uite	Ì	1 XBurial 2 Cremation 3 Removal from State K	Place of Disposition crematory or other ing Mem.	r place)	~	Date -28-12	20c. Location - City or Randallst	
altin mit. P. spartme sportan	1	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee		me and Addres			neral Home	P.A.
	_	23a. Part I. Enter the disease, or complications that aused the deat	, 638	8 N. Gi	lmor Str	eet Balt	imore, Mar	yland 21217 Approximate Interval
Physician /Medical	ļ	failure. List only one cause on each line. Immediate Cause (Final disease a Choking	n. Do not oner the	s mode of dying	, such as calculact	or respiratory arres	st, shock, of fleat	Between Onset and Death
Txaminer		or condition resulting in death) Due to (or as a consequence	of):					
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	of):					
_ ;;	Examiner	events resulting in death) Last Due to (or as a consequence	of):					
be executed ician and urial - transit	dical E	d d						
'60, ate be e	Medi	IF FEMALE: 23c. If yes, outcome of pre	gnancy			-	23d. Date of deliver	,
Box 68760 to death certificate be the attending physicate for use as the burner of the burner as the	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of c	leath -	il death 3 er (Specify)	Ectopic pregn	ancy	Month (Day Year
BO) he death	hysi	1 Yes 2 No 9 Unknown 9 Unknown						
P.C es that	2	Part II. Other significant conditions contributing to death but not	resulting in the unc	derlying cause	given in Part I.		eacco use contribute to 2 No 3 Prot	
of Vital Records, ig Physician: The law requiring the this certificate has been sineral director, page 2 should be	Completed					24a. Was ar autops		topsy findings available completion of cause of
of Vital Records ing Physician: The law requi After this certificate has been uneral director, page 2 should	E O					perform	ned? death?	
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner? Hospital:	✓ ER/Outpatient		of Death (Check		Residence 6 Othe	
of V ng Phys After thi uneral d	٤	27. Manner of Death 28a. Date of Injury	28b. Time of Inju		ury at Work?	28d. Describe ho	ow injury occurred	
Division tal or Attendin rs after death. al Director: A led in by the fu	gatio	1 Natural 5 Pending Nov 13, 2012 Pending 2 ✓ Accident Investigation	0933 hrs	900 L 1 L 100 L	Yes 2 V No	Subject chok		
Division or A state or	Certification:	3 Suicide 6 Could not be determined (Specify) Emergen		, factory, office	building, etc.	or Town, Sta		ral Route Number, City thts, MD
Division of ^N To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowle one) 2 V Medical Examiner: On the basis of examination	dge, death occurre			d due to the cause	(s) and manner as stat	ed.
To with To com	Mec	29b. Signature and title of certifier			se number		29d. Date signed (Mo	
		10	<i></i>	0.0	.M.E.		November 15, 26	012
3,		30. Name and address of person who completed cause of death (Ite Russell Alexander MD Assistant Medical Exa		V. Baltimore	Street. Baltir	more, MD 212	23	
		21 Date filed (Month Day Voor)				, 212		

Registrar

	4	For State		State of	Marylan				id Mental Hy	giene 2	012	37108
		Registrar 1. Decedent's Name (Fig. 1)	First Middle 12	ast)		Cen	tificate of E	<i>Jeatn</i>	2. Date of De	Reg. No.	016	3. Time of Death
Physician	/	Louise	- /	Bristo	1				Month NOV	Day 13	20/2	6:30 PM
Medica Examine		4a. Facility Name (if not					4b. City, Town, or	Location of D		4c. Cc	ounty of Deat	h
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Funeral		5. Social Security Numb			. Age (In yrs. Ia	st birthday)	If Under 1 Year Months Days	If Under 24 Hours N	Min. (Month, Da	y, Year)	Cos	thplace (State or Foreign untry)
Director	١	219-16-3 Usual Residence of D		1 □ M 2 😿 F	93	Yrs.			5/16/	19	S	SC
land shov	اةِ		0b. County		10c. City	, Town or Loc	ation					10d. Inside City Limits
Mary 28a-f otifie	Director	MD	N/A		F	Baltim						1 Yes 2 No
th the		10e. Street and Numbe		7 1			10f. Zip Code	_			n of What Co	ountry?
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0 2.9	۵	1 ☐ Never Married 3 ☐ Widowed 4 ☐		Armed Ford	ces? 2 🔀 No	l If	Yes, specify Cuba	n, Mexican, P	uerto Rican, etc.)		Black, White frica ecily:	e, etc. N
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215 lin 72 le. han ";	ᇎ	Elementary/Second		rade completed) College (1-4	1 or 5+)	life. DC	ind of work done o NOT use retired)		working	Se	elf	
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ance file antal h ked o		Milton B	. , ,						Name (First, Middle,		riairie)	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	ŀ	19a. Informant's Name				19b. Mailine	g Address (Street a		r Rural Route Numbe		wn, State, Zip	o Code)
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Baltimore, Manageria Page 1 and 2 st permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other transonce.		20a. Method of Disposi 1 ☐ XS urial 2 ☐ 6 4 ☐ Donation 5	Cremation 3		State C	emetery, crem	sition (Name of atory or other plac n Fores		1/28/12		tion-City or gs Mi	
Baltii permit. F Departm Importa any inju	ŀ	21. Signature of Fune							ari P. (Close	F.Sv	s.PA
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		23a. Part 1 Enter the shock, or heart fa		mplications that ca one calk e on eac	used the death h line.	n. Do not ente	r the mode of dying	g, such as car	diac or respiratory a	rrest,	_	Approximate Interval Between Onset and Death
Priysician/ Medical	ı	Immediate Cause (Final disease or condition resulting in death)	al	a. 47H	EROSC	HERO	TIC C	EREF	BRO VA	SCOLL-	AR	Onset and Death
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	le	Sequentially list condition if any, leading to imme	ediate 🌃	Due to (c	r as a consequ	ence of):						
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60 ate be executed hysician and the burial-transit		resulting in death) Las	st	Due to (c	r as a consequ	ence of):						
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Box 687 death certifica he attending p led for use as i		IF FEMALE: 23b. Was decedent pre	egnant	23c. If yes, outo	ome of pregna	ncy				23	d. Date of de	livery
Sox	icia	in the past 12 mor	nths?	4 Pregn	ant at time of c		Ectopic pregnand Other (specify)	У			Month	Day Year
ords, P.O. Borders that the despensioned by the should be detached	ڄ	9 Unknown		9 Unkno								
P.O.		Part II. Other significa	POROSI		ath but not res	ulting in the ur	nderlying cause giv	en in Part I.				the cause of death?
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law r	ᇍ	Dusp	MHUI	<i>F</i> -1					— 24a. Was	s an opsy ormed?	prior to death?	topsy findings available completion of cause of
/ital Reco		25. Was case referred t	to medical				00 FI		1 Yes	P No	1 🗌 Yes	s R No
/ita	lo Be	examiner?		Hospital:	npatient 2 🗆	ER/Outpation	Oth		ing Home 5 Res	idence 6	Other (Spec	nifu)
of \ g Phy er this neral c		27. Manner of Death			of injury	28b. Time of	28c. Injun	y at	28d. Describe			ony)
on endin eath. or: Aft	lical	2 Accident	5 Pending Investigati	on	i, Day, rear)	injury	M 1 🗆	Yes 2 No	0			
	Certificate:	3 ☐ Suicide 6 4 ☐ Homicide	6 Could not determine	. 128e, Place (of Injury - At ho g, etc. (Specify	me, farm, stre)	et, factory, office		28f. Location (City or To	(Street and N wn, State)	lumber or Ru	ral Route Number,
Hospit 24 hour Funera	Medical	(Check 2	Medical Exam	miner: On the basis	s of examination	and/or invest	igation, in my opinio	on, death occu	ace, and due to the corred at the time, date and place, and due to	and place, ar	nd due to the	cause(s) and manner stated.
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To the within 2 To the comple		29b. Signature and title	e of certifier	1	Λ		1 2 -	10.0.				
To the within 2 To the comple		4	e of certifier	Lau	lan	m	1 2	18595		11	15/12	
To the orthodoxy		Jas 30. Name and address TASNEE	LULLU s of person who	AKHAM	1, mi	P.0			DWINGS	Mill	- mi	21117
To the Complete Registral	è	30. Name and address ASNEE 31. Date filed (Month, L	LULLU s of person who	AK HAN	e of death (Item I, M) gistrar's Signat	P.0	rint)		DWINGS	Mill	15/12 - M)	21117

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 55 Medical 4a. Facility Name (if not institution, give street and number **Examiner** Town, or Location of Death 4c. County of Death OV If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours 216 28 4964 **Director** 1 DM 2 X F Yrs 79 24 1933 Virginia 06 28a-f show 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director "natural", or items 23a or 28a-f sl edical Examiner must be notified 1 Yes 2 X No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 U.S.A. 7466 Furnace Branch Rd Apt 316 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No by Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Completed 3 ☒ Widowed 4 ☐ Divorced White Year or Dates marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. 12 Motor Vehicle Admin Clerical Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kelly Jack Rogers Estelle Barnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Health a Louise Terrace Glen Burnie, MD 21060 Linda Hunt - Daughter 125 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1.
Department of I Important: If it any injury or of once. ŏ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/15/12 Veterans Cem Crownsville, MD 21. Signature of Eugeral Service Licensee GJ Gonce Funeral Home, 21122 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine Duel to (under a done equence of) cause. Enter Underlying Cause (Disease or injury and burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year Day Pregnant at time of death Other (specify) the a 🗌 Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has I autopsy filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manur of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical within 24 hour To the Funer completely file Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of certifie

lell

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

25

29d. Date signed (Month, Day, Year)

53606237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. amend 23a. Pt. I & II,25,27,28a-f,per me,g935 1-17-13 SM State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Pth 2013 Month 4a. Facility Name (if not institution, give street and number) NOVLM 3:08AM Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death Kandal Honer 24 Hrs. Daltimore Hospital Center If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) Director 217 13 8493 1 M 2 X F 30 09 07 1982 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be nothered at once. 10c, City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11304 Butler Rd 21629 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 M No
If Yes, Give
Year or Dates. 1 Never Married 2 X Married ۾ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Michael F. Riedy Jane Eileen Mrockrowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ryan Blackiston - Husband 11304 Butler Rd Denton, 21629 MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Toremation 3 Removal from State Bayview Crematory 4 Donation 5 Other (Specify) 11/19/12 Baltimore, MD 21. Signature of Funeral Servicensee 22. Name and Address of Facility GJ Gonce Funeral Home, PA169 Riviera Drive Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Hanging Due to (or a a consumence of): Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Pharmanio Due to (or as a consequence of Exami CERTIFICATION APPROVED BY MEDICAL EXAMINER To the Hospital or Attenuing ringsoccase, within 24 hours after death,

To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Day Year 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Previous SHONA 1 Yes 2 0 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Comonic Wachentone autopsy performed? Yes 2 N 1 ☐ Yes 2 No æ 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: ဍ 1. Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury subject hanged self 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 🛣 No Investigation fd 7-3-12 12:40 AM 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 101 Gay St. determined Carolin County Detention Center Denton, MD. Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of cartifie 29c. License numbe 10056632 30. Name and address of pe rson who completed cause of death (Item 23a) (Type, Print) 012 5401 Day, Yes State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 Month 1756 PM NATHANIEL LEE **CASEY** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNION MEMORIAL HOSPITAL ER N/A BALTIMORE Social Security Numbe If Under . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Hours Months Min. Director 1 🖾 M 2 🗆 F 223-20-8510 Yrs 89 28 1923 MAR. VIRGINIA Usual Residence of Decedent . Page 1 and 2 should be filed within 72 hours after death with the maryianu thent of Health and Mental Hygiene.
tent: If item 27 is marked other then "natural", or items 23a or 28e-f show hinr or other treumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X☐ Yes 2 ☐ No MARYLAND N/A BALTIMORE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1102 DRUID HILL 21201 AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 XJo Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: BLACK If Yes Give Specify 3

Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) CEMENT MAKER 6th grade CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIAM CASEY LUCY CASEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille McCray/Daughter Springfield Gardens, 173rd St., NY. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportent: If ite
eny Injury or ot Date XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ZION CEMETERY 11-20-12 LANSDOWNE, MARYLAND . Signature of Funeral Ser Name and Address of Facility
ILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
206 W NORTH AVENUE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final disease or condition Onset and Death Physician 1600 Y.1 Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Proystotem, me, within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag perform 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Magner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural Natural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) consta e no 31. Date filed (Month, Day, Year) 32 gistrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ November TANYA 2012 Υ, CANNON Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FUTURE CARE LOCHEARN BALTIMORE 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Hours Min. Director Country)
MARYLAND 217-84-2972 48 Yrs. 964 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1XXYes 2 No MARYLAND N/A BALTIMORE 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? by Funeral 2103 W. MULBERRY STREET 21223 U.S.A. "natural", or items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify: Specify: BLACK Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "any injury or other traumatic event, the Mea any injury or other traumatic event, the Mea life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12yrs HOUSEWIFE DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ WILLIE CANNON MAXINE TUCKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Gregory D. Perry/ Brother</u> 2103 W. Mulberry ST., Baltimore, Md., 21223 20a. Method of Disposition
1 ☐ Burial, 2 ☒ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Dopation 5 ☐ Other (Specify) METRO CREMATORY 11-15-2012 BALTIMORE, MARYLAND 21. Signal of Fune I Service Line 22. Name and Address of Facility
WILLIAM C BROWN COM
1206 W NORTH AVENUE COMMUNITY FUNERAL HOME P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year signed by the a d be detached f g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? death? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 XN funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work 1 Tes 2 🗌 No Accident Investigation after death Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотріете 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death t's Name (First, Middle, Dast) 2. Date of Death Physician/ lovember 15, 2012 rrinaton Medical Examiner n, give street and n Town, or Location of Death ospice Baltimore limonium Age (In yrs. last birthday) Funeral If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 216-36-13 Hours Min Director 1 □ M 2 🖬 F 28e-f ehov item 27 is merked other then "neturel", or items 23e or 28e-f eho other treumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore 1 Yes 2 No 10e. Street and Numb 10f. Zip Code 10q. Citizen of What Country? Funeral 21206 trnnem 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Page 1 and 2 should be filed within 72 hours effer c Inspertment of Heelth and Mental Hyglene. Importent: If Item 27 is merked other than "neturel", or leny injury or other treumetic event, the Medical Examinance. þ Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No If Yes, Give Year or Dates 1 Yes 2 No 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Soeech (Give kind of work done of life. DO NOT use retired) Elementary/Secondary (0-12) llege (1-4 or 5+) lears Be Fattler's Name (First, Middle, + 18. Mother 's Name (First, Middla, Maiden Suma ဥ DOVE City or Town, State, Zip Cod 21229 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ry or other place 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear Meliure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cerrica disease or condition resulting in death) Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Itijury that initiated example. Due to (or as a consequence of): signed by the ettending physicien end d be deteched for use es the buriel-trensit Hospitel or Attending Physicien: The law requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical らしかしいしい Massell of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Dav Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Certificate: To Be Completed 1 🗌 Yes 2 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, pege 2 a autopsy performe death? 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Marther of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred - ARRING Division o Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Deficial Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hound to the Funer completely file 29a. Certifier (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print RNP 2 State NOV 1 Registrar DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:20 PM M November John Campbell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Overlea Health & Rehab Ctr 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, FEb 23, 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours CAlifornia 1 M 2□ F FEb Director 83 579-36-5889 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examinat must be notified at Director 1√2 Yes 2 No Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21206 6116 Belair Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 □ No UI 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □Yes 2 □
If Yes, Give
Year or Dates: unk 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2√∑No Specify 2 Specify: white 3 Widowed 4 Divorced Be Completed Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Overlea Health & Rehab Ctr 6116 Belair Road Baltimore, MD 21206 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state 21. Signato Fineral Service Lio 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 23a. Pand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. چ ک 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 2 HNo 2 1100 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending thours after death.
uneral Director: Afely filled in by the fur 1 □Yes 2 □No investigation 2 Accident Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a ✓ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

Jayant

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

21215-0036

p

P.O. Box 68760,

Division of Vital Records,

11-08-12

TOWSUN MO 21202

12-08619								
Bryant	J	Κ	Dew					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ryant J K Dew		State of Maryland / Department of Health and Mental Hy 1- For State Certificate of Death	/giene
Physicia	_	Registrar 1. Decedent's Name (First, Middle, Last)	Reg. No. 2 3 1 2 2 Date of Death 3. Time of Death
ledical Examir		Bryant J. K. Dew	November 13, 2012 1330 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1-695 at Exit 17 Woodlawn	4c. County of Death Baltimore County
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		220-21-1723 1 Mm 2 F 30 Yrs. Months Days Hours Min.	09/26/1982 Country MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryland 28a-f sbow 1 at once.	ţ	MD Howard ElKridge	1 Yes 2 No
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23s nr 28s-f she matic event, the Medical Examiner must be notified at once	Director	106. Street and Number 6475 Old High gate Drive 21075	10g. Citizen of What Country?
th with cms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 2 Armed Forces? 1 If Yes, specify Cuban, Mexican, Puerto	
fter dea		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:	Specify: Black
hours at natural Sxamin	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of volume and the property of working life. DO NOT use reliable to the property of the property o	vork done 16b. Kind of Business/Industry
hin 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	icialist Communications
5-0036 iled within 72 Hygiene. I other than '		17, Father's Name (First, Middle, Last) Communication 5 Open 17, Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Maiden Surname)
D 2121 should be fi and Mental I 7 is marked	To Be	19a. Informant's Narge/Relationship (Type, Print) 19b. Mailing Andress (Street and Number of F	tra Nash Rural Route Number, City or Town, State, Zip Orgel 7 (7)
e, MD 1 and 2 show Health and 1 item 27 is r traumatic		Syrita C. Dew/Wite 1856 Comar Rd., R	altimore, Maryland
MOCE, Pages 1 and tent of Healt int: If item		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 Cremation 3 Removal from State	Date 20c. Location - City of Town, State
- E 22 G		4 Donation & Other Specify 21. Signature of Funeral Service Liberises 22. Viv. and Judgess of Accility. Co.	30 12 Cwings Mills, MD
Balti permit. Departm Imports injury		21. Signature of Funeral Service Liberises 22 No. 10 Judgess of Pacifity Co. 10 Judgess of Pacifity Co	1 Pike (21229)
Physician /Mii		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List any one cause on each line.	r respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Intra-oral Shotgun Wound Due to (or as a consequence of):	Deau
Value"	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	Examiner	cause. Enter Underlying Cause (Uisease or injury that initiated	
		events resulting in death) Last Due to (or as a consequence or): d.	
- a :5:13	edical	UNPENDED AMENDED	
x 68760 h certificate t tending physi use as the bu	an/M	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 2 Fetal death 3 Ectopic pregnancy 2 Fetal death 3 Ectopic pregnancy 3 Ectopic pregnancy 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery Incy Month Day Year
Box 6876C e death certificate the attending phys ed for use as the b	Physician/Me	4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
. # 7.4	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown
of Vital Records, P.O in Physician: The law requires that it there this certificate has been signed by neral director, page 2 should be detac	eted		1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available
Recor The law r icate has b	Completed		autopsy performed? performed? death? 1 Yes 2 No 1 Yes 2 No
tal Rection: The	Be Co	25. Was case referred to medical 26.Place of Death (Check examiner?	only one)
f Vit	유	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA	
on of ending Pl ath. or: After he funera	Certification:	1 Natural 5 Pending FOUND: Pending FOUND: 1 Yes 2 V No	28d. Describe how injury occurred Subject shot self
Division To the Hnspital or Attendit within 24 hours after death. To the Feneral Director: /	tifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Inspital f hours f hours		4 Homicide determined (Specify) Interstate 29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	or Town, State) I-695 at Exit 17, Woodlawn, MD
To the Hm within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	
F > F 0	ž	29b Signature and title of certifier 29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)	November 14, 2012
		Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltim	nore, MD 21223
Sta Regist	ate rar	31. Date filed (Month, Day Year) 32. (egistrar's Signature) 32. (egistrar's Signature)	OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible amend #31 Per DVR G933 11/19/2012 JH State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Desroches Physician/ Month Louise 7325M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cross HOSpital HOLL SILVER Montgomery (oun+ If Under 1 Year | If Und Social Security Number Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace State or Foreign Funeral Min Months Davs Hours Country) Director 579-38-0084 1 M 2 IOWA if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d Inside City Limits Director 1 Yes 2 No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 USA 3116 Gracefield Road #316 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) housewife own home 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Katherine Louise Thompson Chester Elwood Leese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2621~Horsham~Road~Hatboro,~PA~19040Michelle Chalumo/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1
Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signatur of Fundal 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director uni, Baltimore, MD 21201 23a. Part 4. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final Physician/ disease or condition resulting in death) Medical e to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate Examine igned by the attending physician and be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 1 Yes 24 No page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 1 Yes 2 🗌 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examine? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ER/Outpatient 3 DOA Inpatient 2 completely filled in by the funeral 28a. Date of injury (Month, Day, Year) eath 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: atural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one icense number 328 d address of person who leted cause of death Item 23a) (Tyole, Print) Date filed (Month, Day, Year) 32. Registrars State Registrar

ÖRIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DEMOUY Month November 8, 2012 4:40AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care Potomac Montgomery Potomac Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, March 8 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours 578-52-7771 **Director** 72 Yrs 1940 Washington D.C. Usual Residence of Decedent show or 28a-f shown notified at 10b. County with the Maryland 10a, State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Montgomery Chevy Chase 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 8809 Altimont Lane 20815 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. 1963 – 1965 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) 5+ Elementary/Seconday (0-12) I Hygiene. Energy Economist Federal Government permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Louis F. DeMouy Ruth Decker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane DeMouy / Wife 8809 Altimont Lane, Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of Monte Omer Y or other place) Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Demoval from State November 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2012 Si natur of Funeral Service de Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MESOTHELIOMA METASTATIC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner THRIVE FAILYRE Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this

Registrar

8218 Wisconsin Avenue #305, Bethesda, Maryland Pinky Singh, M.D. 32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

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	State Registrar					Cer	rtificate of	Death		Reg. No. 2	2012	371
an	1. Decedent's Nan								2. Date of Dea	Day	Year	3. Time of Deat
cal	4a. Facility Name			d number)			4b. City Town	or Location of Death	NOVEMB		unty of Deat	
er	Johns Hop				Center		Baltimore				1	RE CITY
	5. Social Security I		6. Sex	7. Age		ast birthday)	If Under 1 Year Months Days		8. Date of Birt	:h	9. Birl	thplace (State or Fore
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Director	MD	BAL	TIMORE		RE	ISTER	STOWN					1 ☐ Yes 2 💢
	10e. Street and Nu						10f. Zip-Code	Ü	n of What Co	untry?		
Funeral		20 BLAKE COURT 11. Marital Status 12. Was Decedent Ever in U.S.					21136	Hispanic Origin? (S	necify Yes or No-	USA	. Race - Ame	nican Indian
	1 Never Mar	ried 2 🗌 Mar	ried 1 🗆	ed Forces? Yes 217			If Yes, specify Cul	oan, Mexican, Puert	o Rican, etc.)		Black, White	e, etc.
b S	3 🗌 Widowed	4 X Divorced	. If Ye	s, Give or Dates:			1 ☐ Yes 2X No	Specify:		S	pecify:WHI	TE
Completed	(Spe		nt's Education est grade comple	eted)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	rking	16b. Kind	l of Business	/Industry
d Ho	Elementary/Sec	condary (0-12)	Colle	ege (1-4 or 5 2	+)	ille.		STRATOR			TOHNS	S HOPKINS
B B	17. Father's Name	(First, Middle,	Last)			<u> </u>	ADIIIN	1	me (First, Middle	, Maiden Si		5 HOEKINS
면 일	GERALD				5	SILVER		MITZI			BU	RKE
	19a. Informant's N	lame/Relations	ship <i>(Type. Print</i>	,		19b. Maili	ing Address (Stree	et and Number or R	ural Route Numb	er, City or 1	Town, State, 2	Zip Code)
	GARY S		SON		look D				DR., #11		UDERH	LLL,FL 333
	1 💢 Burial 2	Cremation	3 🗌 Removal	from State	T	ace of Displ emetery, cre LFERET	osition (Name of matory or other pl 'H TSRAF.I	ace)			•	
	21. Signature of Fe	5 Other (Superal Service			A	NSHE S	H ISRAEI SFARD 2. Name and Add	ress of Facility S	16/2012 DI LEVIN		SEDALE	
	Ma	nit C	_									, MD 2120
	23a. Part 1. Enter shock, or hea	the disease, o	r complications only one cause	that caused on each lin	the death	. Do not en	ter the mode of d	ying, such as cardia	c or respiratory a	arrest,		Approximate Interval Between
	Immediate Cause disease or condition	òn	_a C	ARD	AC	ARY	PEST					Onset and Death
	resulting in death)		Di	ue to (or as	a consequ	ience of):						
ě	Sequentially list co	onditions, mmediate	D.	ue to (or as	a consequ	ience of):						
Examine	Cause (Disease of that initiated event	erlying • r injury	s 1	NHAI	ATIO	N I	WINDOW WE BLOCK STANDINGS					
- 1	resulting in death)			ue to (or as	a consequ	ience of):		au AP	ROVEUBI			
dical			d	SURN) 1	MM	-4	CENTIFICATION.	- A			
/Me	IF FEMALE:		23c If ve	es, outcome	of pregna	nev	,	0,0	Ú-		.d D-46 d-)
Physician/Medic	23b. Was deceder in the past 12	2 months?	1 0	Live birth Pregnant at	2 🗌 Fetal	death 3	☐ Ectopic pregnar	псу		23	d. Date of de Month	Day Year
TyS.	1 Tes 2 9 Unknowr			Unknown								
ру Р	Part II. Other sign	ificant condit	ions contributing	g to death b	ut not res	ulting in the	underlying cause	given in Part I.	23e. Did	tobacco use	e contribute 1	to the cause of death
									1 🗆	Yes 2		robably 4 Unkn
Completed									24a. Was auto		24b. Were a prior to death?	utopsy findings avail completion of cause
	05.14/								1 🗆 Yes	2 No		s 2 No
20	25. Was case refe examiner? 1 Tes 25		Hospital	: 1 Inpatie	nt 0 🗆	ED/Outpotio	nt 3 □ DOA O	ther:	ath <i>(Check only c</i> Home 5 ☐ Resi		Other (See	noife)
2	27. Manner of Dea	ath		Date of Inju	ry	28b. Time	of 28c. Inj	ury at	28d. Describe	how injury	occurred	
atio	1 ☐ Natural 2 🔀 Accident	5 🗌 Pendi invest	ng igation	(Month, Day	12	0108		ork? ☐ Yes 2 ✓ No	Subjec	TINI	voived 1	in House Fl
ertification:	3 ☐ Suicide 4 ☐ Homicide	6 🗌 Could deterr	minod 200.	Place of injuding, et) . /	reet, factory, office)	City or To	vn, State)	Number or F	Rural Route Number,
0	20a Cartifica	1 Manual	ne Dhualaian i	To the best	of many law as		ne	tions whate and misses		ake	CT.	
edical	29a. Certifier (check only one)		I Examiner: On		f examinat			time, date and place opinion, death occ				
Mec	29b. Signature an	d title of certific		-			29c. Licer	nse number	· ·	29d. Date	signed (Mon	th, Day, Year)
	* Du	~ N		M			- 1023	337485	57	NOVE	MBE(-	-14 201
	30. Name and add	dress of person	n who complete	d cause of	death (Iten	n 23a) (Type			100	, , ,		

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 16, 2012 12:25 PM Diane Eurice Linda Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lutherville Baltimore Stella Maris 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min. (Month, Day, Year) Hours Director 213-36-2513 1 🗆 M 2 🔀 F 72 Yrs. Maryland 03/31/1940 Usual Residence of Decedent permit. Pege 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Heelth and Mentel Hyglene.
Important: if item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other treumetic event, the Mexical Examiner must be notified at once. 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Essex 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21221 1633 Cape May Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 M Married δ and 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Retail Sales Associate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna Schilling Stuart Franklin Goetzke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1633 Cape May Road, Baltimore, Maryland 21221 Eurice (Husband) Robert Ρ. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State St. Joseph Church Cemi11/20/2012 Fullerton, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Eacility Ski Funeral Home, P.A Signature of Fundral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. 5 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm te Cause (Final Physician/ dise e or condition resulting in death) Medical Due to (or as a con- x uence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The lew requires that the deeth certificate be executed ettending physicien and I for use as the burlai-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ト・IV シャー ・ W R)とと Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Yo

9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No Completed 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed 1 ☐ Yes 2 🔀 death? 2 🗌 No 1 🗌 Yes funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 📈 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 6 Other (Specify Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury To the Hospital or Attendir within 24 hours efter deeth.

To the Funerel Director: Af completely filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) rson who completed cause of death (Item 23a) (Type, Print) 2310 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ November 10, 2012 Debora Janet Eisenbeiss 6:05 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 579-84-1071 Director 1 🗆 M 2 🗓 F 58 June 29, 1954 Washington, D.C. Hygiene. other then "naturai", or items 23a or 28e-f show rent, the Medical Examiner must be notified at death with the Maryland 10a, State 10b. County 10c. City, Town or Location Director Maryland Montgomery 1 ☐ Yes 2 X No Kensington 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 3000 McComas Avenue 20895 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: 3 Divorced 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled n/a I and 2 should be filed w I Health and Mentel Hyg Item 27 is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Victor M. Eisenbeiss, Sr. Beatrice Kline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Eisenbeiss/Daughter 308 Philadelphia Avenue, Takoma Park, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pege 1 Department of Important: If its any injury or of November 20 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rock Creek Cemetery Washington, D.C. 2012 21. Signature of Funeral Service License 22. Name and Address of Facility
Robert A. Fumphrey Funeral Home,
7557 Wisconsin Avenue, Bethesda, Bethesda-Chevy Marvland 20814 Chase, Inc. Milla 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Complications of Diabetes disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attention. for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Dav Pregnant at time of death signed by the at id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Chronic Obstructive Pulmonary Disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown page 2 should Adrenal Insufficiency 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Hypertension 1 ☐ Yes 2 X No Yes 2 No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 🔀 No 1 Tes မှ 1 ☐ Inpatient 2 🕅 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 XNatural 1 🗌 Yes 2 🗌 No ☐ Accident Investigation 3 D Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signat 29d. Date signed (Month, Day, Year) D24348 11/10/2012 completed cause of death (Item 23a) (Type, Print) RVEN 1500 Forest Glen Road, Silver Spring, MD 20910 SVU State Registrar

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD.

NOV 1

31. Date filed (Month, Day, Year,

Assistant Medical Examiner

OCME

900 W. Baltimore Street, Baltimore, MD 21223

November 9, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Frazee onovan ovember :55A 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice @ Northwest Hospital Baltimor Randallstown If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director <u> 220–56–6515</u> 1 X M 2 A F 59 Aug 17, 1953 South Carolina Usual Residence of Decedent th end Mental Hygiene. 27 is marked other then "naturel", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Laure1 1 ☐ Yes 2 ▼ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 13402 Arden Way #3 20708 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify 3 Widowed 4 Divorced white Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) n installer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of the stand 2 should be fit of Health end Mental fitem 27 is marked rother treumatic ev 2 Donovan Byron Frazee Jr Mildred Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Montee Frazee/brother 10102 Garis Shop Road Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Depertment of H
Importent: If ite
eny injury or ott cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 📉 Other (Specify) in state 21. Signature Funeral Secrete Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 ern 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Liver (ancer disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Lipury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-transit end Due to (or as a consequence of): the attending physicien the for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown Division of Vital Records, P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 € 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 - Nursing Home 5 - Residence 6 - Other Breaky than haspice 2 - No ည 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Natural 5
Pending injury within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Defitying Prijaction. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. NSRajapahlMD 29c. License number D0057-46-5 Baltimore MDZ1209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NS Rajapakte MD 5 203 2835 Smith

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year) NOV 1 9 2012

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/illiam E Ferrell		1- For State	ate of Maryla		tment of		and	Menta	al Hy		- 11-	2012	3712
Physicia		Registrar 1. Decedent's Name (First, Middle	,Last)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				2	. Date of Death		<u> U 1 6</u>	3. Time of Death
ledical Examin	ıer	William E. Ferrell 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death									0838 hrs		
j		4a. Facility Name (if not institution 8810 Walther Blvd #23		mber)	ľ	lb. City, To Parkvill		ocation of	Death			ounty of Death imore Cou	
Funeral				7. Age (In yrs, last	t birthday)	If Under		If Under	24Hrs.	8. Date of Birth			hplace (State or
Director	ı	141-24-4587	1XM 2F		Yrs	Months	Days	Hours	Min.			Foreig	n
	H	Usual Residence of Decedent	125,111	79				L		Dec 7.	1932	4	ew Jersey
v any		10a. State 10b. County		10c. City, To	own or Locati	on			_				10d. Inside City Limits
faryland 28a-f show	힐	MD Balti	more	Pa	rkvill								1 Yes 2 No
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland in and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shounatic event, the Medical Examiner must be notified at once	Director	10e. Street and Number 8810 Walther B	1vd #2326			10f. Zip C	^{ode} 2123	2 /1		10	-	of What Cour	ntry?
ith the		11. Marital Status		edent Ever in U.S.	13 W/s				n2 / Sner	cify Yes or No-			can Indian, Black,
eath w	Funeral	1 Never Married 2 X Ma	rried Armed Fo	orces?		es, specify					1-7.	White, etc.	carr moian, black,
ifter d	E E	3 Widowed 4 Divo	1 X Yes		5 1	Yes 2 X	No	specify:			Spe	ecify: whi	te
nours a	eted b	15. Decedent's Education (Spec		le completed) 1	6a. Deceden	t's Usual Oc					16b. Kind	of Business/I	ndustry unk
36 n 72 h	plet	Elementary/Secondary (0-12)	College (1	-4 or 5+)						-7			
5-0036 led within 72 hours a Hygiene. cother than "natura the Medical Exami	Comple	12 17. Father's Name (First, Middle.	Last)		sale	spers		B. Mother's	Name (F	First, Middle, M	aiden Sur	name)	unk
D 21215-003 should be filed within and Mental Hygiene. The marked other than antic event, the Med	Be	William Rēins	Ferrell						,	,		,	unk
2121 hould be fill and Mental I is marked ritic event,		19a, Informant's Name/Relationsh	ip (Type, Print)		19b. Mailing	Address	(Street a	and Numb	er or Ru	ral Route Numi	ber, City o	r Town, State	Zip Code)
	-	Elizabeth Fer 20a. Method of Disposition	rell/spou							26 Parl		e, MD	21234
Baltimore, permit. Pages 1 ar Department of Hee Important: Urite injury or other tr		1 Burial 2 Cremation	3 Removal fro		ace of Dispos ematory or oth		or ceme	etery,	'	Date	ZUC. LOC	ation - City or	Town, State
Baltimore permit. Pages 1 Department of H Important: If i	-	4 X Donation 5 Other Sp			I oo w			4.F					
Baltimore permit. Pages 1 a Department of HE Important: If it injury or other t	ļ	21. Signature of Funeral Service I	Jane , I	rector	St	ame and Ada	acress o	my Bo			Bal	timroe	Street
Physician [*]	1	23a. Part I. Enter the disease, or		aused the death. D		ltimo: ne mode of d			2120 diac or r		st, shock,	or heart	Approximate Interval
/Medical		failure. List only one cause of Immediate Cause (Final disease		nshot Wound	of Torso								Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a	consequence of):									
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):									
	틝	cause Enter Underlying Gause (Disease or injury that initiated	C	00/100400/100 0//.									
ed nsit	Examiner	events resulting in death) Last	Due to (or as a	consequence of):									
be executed hician and urial - transi	dical	UNPENDED	a. AMENDED										
	Ş Ş	IF FEMALE:		outcome of pregna	ncv						23d, D	ate of delivery	
x 68760 h certificate b tending physi use as the bu	au'	23b. Was decedent pregnant in the past 12 months?	1 Live b	irth	2 Fe	tal death	3	Ectopic p	oregnand	у	Мо		ay Year
Box cath co	Physician/Me	1 Yes 2 No 9 Unk	nown 9 Unkno	ant at time of death	h 5 Oti	ner (Specify	<i>'</i>)				1		
D. E		Part II. Other significant condition		death but not resu	ulting in the u	nderlying ca	ause giv	en in Part	: I.	23e. Did tob	pacco use	contribute to	the cause of death?
, P.O. res that the signed by be detack	<u>۾</u>									1 Yes	2 🗸 No	o 3 Prob	ably 4 Unknown
rds requir	ete									24a. Was a autops			topsy findings available ompletion of cause of
eco he law ate has	Completed						-			perform	ned?	death?	
tal Rection: The certificate ector, page	Be C	25. Was case referred to medical				26.		f Death (C	heck on				
of Vital Records, ag Physician: The law require Lifer this certificate has been si neral director, page 2 should b	일	examiner? 1 ✓ Yes 2 No	Hospital: 1 I	npatient 2 E	R/Outpatient	3 🔲 DO	^ °	ther ₄		Home 5 F			Scene
1 Of Jing P	<u></u>	27. Manner of Death 1 Natural 5 Death	28a. Date (Month FOUND	of Injury 2 Day,Year) F	8b. Time of In FOUND:	njury 280		at Work?	IS	8d. Describe h ubject shot		occurred	
Attendant death	lăi 	2 Accident Invest	tigation Oct 26, 2	2012 0	0825 hrs	t factory o		s 2 V		9f Lagation (C)	troot and I	Number of Bu	ral Route Number, City
Division tal or Attendi rs af er death. al Director: /	Certification:	deten	not be	e of Injury - At hom Residence	ie, iami, stree	n, ractory, o	nice bui	iding, etc.		or Town, St 310 Walther E	ate)		
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H S H S	ž	29b. Signature and title of certifier		\mathcal{A}		29c. l	icense i	number			29d. Date	signed (Mo	oth, Day, Year)
		alun	in	10	(D.C.M	.E.			Octobe	er 27, 2012	2
	Ī	30. Name and address of person		,		altin- a-	Chrosi	Delli	nore 1	4D 21222			
C+-		Zabiullah Ali, M.D. A 31. Date filed (Month, Day, Year)	Assistant Medic	ai Examiner gistrar's Signatur	900 W. B		SHEE	i, Dailin	iore, N	11U Z 1ZZ3			
Sta Registr		NOV 1 9	2012	gistial's Signatur	par	New Y							
DUBALL 47 D 4400	04			•								(CME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death ^{Day}12, Physician/ November Joe₁ I. Fa1k 2012 3:47 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 511 Bonnibelle Place Rockville Montgomery Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months Days Min. Hours 110-36-1353 Director 1 X M 2 □ F 64 July 8, 1948 New Jersev Usual Residence of Decedent or 28a-f shov item 27 is marked other than "natural", or items 23e or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Rockville Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 511 Bonnibelle Place United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian þ 1 Never Married 2 X Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n:
eny injury or other traumatic event, the Medic (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pharmaceutical Consultant Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Herb Falk Evelyn Siskind 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine A. Falk / Wife 511 Bonnibelle Place, Rockville, Maryland 20850 20a. Method of Disposition
1 □ Burial 2 ঐ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Montgomery Crematory or other place) Crematorium, Inc. November 18. 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Bethesda, Maryland 2012 Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01305 make 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Months Immediate Cause (Final Pnysiciani disease or condition resulting in death) Metastatic Melanoma / Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi ause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): I Director: After this certificate has been signed by the attending physician d in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 🕅 No ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 24 hours Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD32864 November 13, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 5530 Wisconsin Avenue, #1125, Chevy Chase, Maryland 20815 Ari Fishman, M.D. 31. Date filed (Month, Day, Year) NOV 1 9 2012 32. Registrar's Si State ature Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. cedent's Name (First, Middle, Last) e of Death Physician/ Medical 4a. Facility Name (if not institution, give street and umber) 4b. City, Town, or Location of Death 4c. County of Death Examiner SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) Min. Director 216--14-0389 1 M 2 X F 89 06/29/1923 MD 28a-f shov 10a. State 10b. County an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Direct 1 Yes 2 No BALTIMORE MD PIKESVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 725 MT WILSON LANE, #226 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Mamied 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the AGENT REAL ESTATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည DAVID FREIBERG JENNIE REIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 DAVID GREEN / NEPHEW 2208 SOUTH ROAD, BALTIMORE, MD 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o . Page 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH JACOB CONG. 11/16/2012 FINKSBURG, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Physician/ neumon Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or nijury that initiated events resulting in death) Last Due to (or as a consequence of): Exami signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year 9 Unknown Division of Vital Records, P.O. Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown cate has been significant page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe After this certificate 2 🗌 No 1 🗌 Yes 1 Yes 2 Hospital or Attending Physician: director, 25. Was case referred t dedical 26. Place of Death (Check only one) Be examiner? npatient hospice Other: 4 Nursing Home 5 Residence 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural n 24 hours after death. e Funeral Director: Af bletely filled in by the fu death. 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) -State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>012</u> Month Physician/ 7:30A 16 Alverta W. Glover Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Sun Valley Assisted Living Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday) Funeral Months Hours 98 Director 213-10-7767 1 M 2 X F 2-20-1914 MD Yrs Usual Residence of Decedent ir than "natural", or items 23e or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Ves 2X No Carroll Westminster MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 USA 2347 Old Washington Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒No Black, White, etc. Š 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify:white 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e 1 and 2 should be filed within 72 is of Health and Mentel Hygiene.
If Item 27 is marked other than "r
or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Knit Sewing Machine Operator æ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lena Zepp John B. Wagner Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If Item 27 is eny injury or other trau Ronnie Wagner-nephew 2373 Old Washington Rd.,Westminster,MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) Zion Church Cem 11/20/12 21. Sign to of Funeral Service Licens 22. Name and Address of Facility Fletcher Funeral & Cremation were Main St., Westminster, MD 21157 homas 254 E 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inhemonic Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): burial-transit end Due to (or as a consequence of): resulting in death) Last ettending physiclan for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires thet the deeth certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) æ Ast linne Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Ridge

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Nov 8 2012 Year Physician/ 2:00A Robert Leroy Gray Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie 17 Harriet Drive 8. Date of Birth (Month, Day, Year Jan 7, 1964 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Director 1 **xxx** 2 \square F 47 215-88-4005 Yrs. Usual Residence of Decede or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 Yes 2xx No Glen Burnie Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be I Funeral USA 17 Harriet Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Francis Mary McGill Robert Lee Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 17 Harriet Drive, Glen Burnie, MD 21060 Wife Cindy Gray 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🗶 remation 3 ☐ Removal from State Nov 10, 2012 Baltimore, MD 4 Donation 5 Other (Specify Bayview Crematory Name and Address of Facility
Fink Funeral Home, P.A. M01148 Fink Gregory 426 Crain Hwy S., Clen Burnie, MD 21061 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or shock, or heart failure. List or or c Approximate Interval Between Onset and Death Immediate Cause (Final Phytician/ disease or condition Medical resulting in death) r as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Other (specify) signed by the at g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribate to the cause of death? þ 1 🗌 Yes 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 2 25. Was case referred to maccal Be 26. Place of Death (Check only one) Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home funeral 28a. Date of injury (Month, Day, Year) 27. Manner of eath 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 5 Pending tural work? 1 ☐ Yes 2 ☐ No s after death.

I Director: After the function of the function Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after

To the Funeral Directory filled in by Medical Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

DHMH 17 Rev 06-2011

(Check

31. Date filed (Month, Day, Year)

1000

and ddress of person who ampleted cause of death (Item 23a) (Type, Print)

32/Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse, Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

down thead hungher 2126

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 246 ovember Alethea Hursey Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** reneral a stimore lary land N/AIf Under 1 Year If Under 24 His 9. Birthplace (State or Foreign Social Security Numbe 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🂢 F 219-84-7506 Months Days Hours Min 07/10/963 49Yrs MD Director Usual Residence of Decedent 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 749 E. 21202 Preston St. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc Ś 1 X Never Married 2 ☐ Married Yes 2 XNo Baltimore, Maryland 21215-0030 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry Je filed wto. Tal Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) H&S Bakery Baker 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Carl Hursey Mary Curry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2802 Glendale Ave. Parkville, MD 21234 Darlene Dixon (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Mt. 11/21/12 Baltimore, MD Carmel Cem. 21. Signature of Funeral Service Licenset Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave. Balto. MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or linjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No ğ Month Day Year Pregnant at time of death detached signed by the 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď pe 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy has page 2 within 24 hours after death.

To the Funeral Director: After this certificate 2 No Yes 2 No 1 Yes the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar ndi

Name and address of person who completed cause

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of death (Item 23a) (Type, Print)

112

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per inf g933 11-30-12 yt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 15, HAROLD ELLSWORTH HACKMAN Physician/ 2012 7:00P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore City 3405 Oakenshaw Place Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Yea Nov 23, 1 Days Months Hours Director 90 217-26-1132 1921 Pennsylvania Vrs Usual Residence of Deced or 28a-f shov 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No N/A Baltimore City Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 21218 USA 3405 Oakenshaw Place 12. Was Decedent Ever in U.S. Armed Forces? WW I L 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: e Give "natural", Specify: Completed 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Printing other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Hacknan George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 3405 Oakenshaw Place, Baltimore, Maryland 21218 Eileen M. Norton (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☑ Burial 2
☒ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 11/16/2012 Catonsville, Maryland ☐ Donation 5 ☐ Other (Specify) ature of Funeral S ²MTCHELL WINEFELD FUNERAL HOME, IN 6500 York Road, Baltimore, Maryland ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. 23a. Part 1. Enter the disease or complication shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Finer Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. use as the burial-transi ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Patricia Disharoon, M.D., 3414 St. Paul Street, Baltimore, Maryland 21218 31. Date filed (Month, Day, Year) NOV 1 9 2012 32. Registra 's Signa Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:25 A. M Toni Haines November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 167-22-5360 Director 1 M 2 XF 83 Pennsylvania Nov. 15, 1928 filed within 72 hours after death with the Maryland al Hyglene. 1 other than "netural", or items 23e or 28a-1 sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo or than "netural", or items 23e or 28a-f s the Medical Evaminal must be notified D.C. 1 XYes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3025 Ontario Road N.W. 20009 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc 1 Never Married 2 Married ģ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Sales Marketing it. Page 1 end 2 should be filed with trment of Health and Mental Hygler rtant; if item 27 is merked other 1 njury or other traumetic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nicholas Maravich Mary Stepanovich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Haines-Murdocco/Daughter 109 Old Post Road, Wakefield, RI 02879 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Geo. Wash. University 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Nov. 2012 permit. Page Depertment of Important: if any injury of once. Washington, DC 4X Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityColumbia Mortuary Services, P.A. Signatur of Funeral Service Lib /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Seosis Medical resulting in death) Due to (or as a consequence of): Examiner Gatrointestinal Bleed Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying siclen and buriel-transit e Hospitel or Attending Physician: The lew requires that the death certificate be executed 24 hours after death.

2 Hours after death.

5 Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Cause (Disease or injury Acute Renal failure that initiated events Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Urinary Tract Infection Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Uncontrolled Diabetes 1 Yes 2 No 3 Probably 4 V Unknown Asthma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hypertension 1 Yes 2 No Yes 21 N 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 ☑ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 잍 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural iniury 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical To the Hosp within 24 hou To the Funer completely fil 29a. Certifier 11x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar

Irna Brown,

29b. Signature and title of ca

32. Registrar's Signature parke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

1500 forest Glen Road Silver Spring, MD 20910

D72580

29d. Date signed (Month, Day, Year)

November 13, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anne Battaile Hunter November 9, 5:19 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maplewood Park Place Bethesda Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days Hours 414-18-6689 94 1 □ M 2 🌣 F Director Oct. 12, 1918 Tennessee or then "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours efter death with the Maryland Director 1 Yes 2 No Maryland Montgomery Bethesda 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 9707 Old Georgetown Road #114 20814 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health end Mentai Hyglene.
Important: If item 27 is marked other then "ns
any injury or other treumetic event, the Medic (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William George Battaile Anne Ivy Turbeville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4025 South 01d Oak Ave., Boise, Idaho 83706 Ellen B. Hunter/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov. 14, 2012 20c. Location - City or Town, State 1 🔲 Burial 2 🖺 Cremation 3 🔲 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 21. Signature of Furreral Scorice Licensee M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of): ⁴Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The lew requires that the usual continuous or within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Alzheimer's Disease 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted Living Other: 4 Nursing Home 5 Residence 6 A Other (Specify) 1 Yes 2 🖾 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 2 | 3 | only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D26259 November 13, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

Ava A. Kaufman, M.D.

NOV 19

31. Date filed (Month, Day, Year)

2. Registrar's Signature

8218 Wisconsin Avenue #103, Bethesda, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 11. 2012 11:50 PM Elizabeth Hengerer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chevy Chase
If Under 1 Year I If Under 24 Hrs. Brighton Gardens Montgomery 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Director 094-12-4428 1 - M 2 X F 94 August 3, 1918 New York ms 23a or 28a-f show must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 5555 Friendship Boulevard #708 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Page 1 and 2 should be filed within 72 hours after deat ment of Health end Mental Hygiene. Fart: If item 27 is marked other than "natural", or iten jury or other traumatic event, <u>the Medicel Examiner I</u> 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Raymond Wing Gertrude Mugler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Hengerer / Son 11011 Brent Road, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State November 17, permit, Page 1 a
Department of H
Important: If ite
eny injury or ot
once, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 Years Immediate Cause (Final disease or condition Physician/ Failure to Thrive Medical resulting in death) Due to (or as a consequence of) Éxaminer Dementia 5 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit Cause (Disease of Injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death detached Part <mark>II. Other significant conditions</mark> cont*r*ibuting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ 8 2 No 3 Probably 4 Unknown Completed 1 Tes Arrhythmia been signal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' certificate ☐ Yes 2 🗓 No 1 Yes 2 No 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Assist**e**d Living Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Tes 2 🛛 No ဥ 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npletely f (Check To the Vithin 2 To the I complete only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO MD00060129 November 12, 2012

State Registrar

DHMH 17 Rev 06-2011

10215 Fernwood Road #100, Bethesda, Maryland 20817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sid

Brent K. Cole,

NOV 1 9 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCT Month 2012 DIANA MCNEIL JOHNSON 4:44 AM Medical 4a. Facility Name (if not institution, give street and number) WALTER REED 4b. City, Town, or Location of Death Examiner 4c. County of Death NATIONAL MILITARY MEDICAL CENTER BETHESDA MONTGOMERY Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Days (Month. Dav. Year) Hours Director 295-52-1183 1 □ M 2¥ F 67 Jan. 1, 1945 Australia iral", or items 23a or 28a-f show Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges Accokeek 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 230 Farmington Road West 20607 <u>United States</u> 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces Black, White, etc. à 1 Never Married 2 🙀 Married 1 ☐ Yes 2 🙀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene, Elementary/Secondary (0-12) College (1-4 or 5+) Sculptor Art Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other trainment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leslie Charles Thomas Sedgwick Norma McNeil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 Farmington Road West, Accokeek, MD 20607 William L. Johnson, Jr./Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Howard University
College of Medicine 1 Burial 2 Cremation 3 Removal from State Nov. 10 4X Donation 5 ☐ Other (Specify) Washington, DC 2012 Signature Funeral Service Licensee 22. Name and Address of Facility Columbia Mortuary Services, P.A. /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) a END STAGE DEMENTIA Medical Due to (or as a consequence of) Examiner ALPHA-1 ANTITRYPSIN DEFICIENCY Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Day 5 Other (specify) Pregnant at time of death Month 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig 1 ☐ Yes 2 🔀 No 3 🗋 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? Yes 2 \(\overline{\Omega}\) No death? 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐XNo ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident after death Director: / Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD 47885 CT 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MILITARY MEDICAL CENTER GREGORY DADEKIAN MD BETHESDA MD 20889 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month V. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Baltimore Jeasons Hospice - Northwest handayotown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 239.28.007 (Month, Day, Year) Director 1 **№** M 2 🗆 F Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene, ent If ifew 27.5 If marked of other then "natural", or items 23a or 28e-f show ury or other treumatic event, the Medicel Examiner must be notified at ury or other treumatic event, the Medicel Examiner must be notified at 27 is marked other then "natural", or items 23a or 28e-f sho treumatic event, the Medicel Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Owings Mills MD Baltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 5206 Stone Shop Circle 21117 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: African 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Elementary/Secondary (0-12) 5th grade College (1-4 or 5+) Custodian Social Securiti NIA Be 17. Father's Name (First, Middle, Last) WIK 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sarah Itope Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5206 Stone Shop Circle Owmas Mills MD2117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1:
Department of I
Importent: If its
eny Injury or ot 1 Burial 2 Cremation 3 Removal from State Hanover, MD Cremation Center 11/17/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee 8728 Liberty Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final END-Stay Cardiony o puth Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time = ** IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed? To the Hospitel or Attending ruyswam within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other Specify + hospice မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

ASRAJ AFAIN MO 29c. License number 29d. Date signed (Month, Day, Year) 00057465 11/15/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NSRG GARSEMO 2835 SMISH IN ST Baltimore MD Z1209 31. Date filed (Month, Day, Year) State NOV 19 Registrar DHMH 17 Rev 06-2011

Christopher C. 12-07852 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day October 16, 2012 Medical Examiner 1406 hrs Christopher C. Joblin 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 2604 Annapolis Road Anne Arundel 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Months Davs Hours ^{reign} North ^{Country}Dakota Director 587-59-4828 34 July 25, 1978 1.X M 2. F Usual Residence of Decedent any 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No e notified at once. or 28a-f show Anne Arundel Severn Pages I and 2 should be fited within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
Sant: If item 27 is marked other than "natural", or items 23a or 28a-7 sho or other traumatic event, the Medical Examiner must be notified at once 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21144 USA 2604 Annapolis Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No 1 Yes 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 X No specify: Specify: white <u>≨</u> or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 0 lock repairman pop-a-lock company 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Terry Joblin Lynne Been 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karla Joblin/stepmother 5186 Water Ridge Drive Tupleo, MS 38801 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department 4 Donation 5 Other Specify: in state 21. Sign of Funeral Service Licer 22. Name and Address of Facili State Anatomy Board 655 W. Baltimore Street Wade, Director Baltimore, MĎ 21201 Physician Rart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line. Between Onset and Medical Death a Quetiapine Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical \square AMENDED 23a, 27, 28a-f, per me, g934 12-3-12 sm X UNPENDED attending physician for use as the burial Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed Division of Vital Records. has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this 2 No 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 Natural 5 Pending 1 Yes 2 X No unknown Director: fd 10-16-12 fd14:00 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2604 Annapolis Rd. 3 Suicide 6 X Could not be or Town, State) 2
Severn, MD. Wooded Area determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the

within 24 hours after death.

To the Funeral Director:

31. Date filed (Month, Day, Year) NNV 1 9 2012

Pamela E. Southall, MD

withall, mi 30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

Hangely 9

32. Registrar's Si nature

Assistant Medical Examiner

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

State Registrar 29d. Date signed (Month, Day, Year)

October 17, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Physician/ Month Keeni 4:30 PM harles Novembe 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis multimedical Center Baltimore TOWSON If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Social Security Number Months Days Hours Day, Year) Min. 168-14-2357 Director 9/22/1921 1**X** M 2 □ F MARYLAND 91 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10d. Inside City Limits death with the Maryland 10c. City, Town or Location Examiner must be notified at Director 1 🗆 Yes 2 📉 No PARKVILLE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 1535 CLEARWOOD ROAD 21234 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. by 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates. WWII Specify: WHITE 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) RAILROAD CAR INSPECTOR 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ PEARL MARCHALL CHARLES HOWARD KEENY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 NANCY F. KEENY/WIFE 1535 CLEARWOOD ROAD PARKVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State ST. ceretave (175 IND) the Cere) 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY 11/21/2012 MILLERS, Fine and Address of Facility JOHNSON-FOSBRINK FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MOO2 17 21286 8521 LOCH RAVEN BLVD. TOWSON, MD 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic disease or condition ucars Medical resulting in death) Due to (or as a consequence of) Examiner WEEKS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examir <u>4upertensian</u>
Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Years attending physician and for use as the burial-trar Physician/Medical years Hyperlipidemia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Dav Pregnant at time of death signed by the a 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: မ 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred I Director: After the funers 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R097104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genesis Multimedical Center 7700 Tork Rd. Towson, MD 21204 Kale Michelle E. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 8:10 AM M November William E. Koeppel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11 Tamarac Trail Baltimore Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Hours Min 118-24-5468 Director 1 XM 2 - F 80 1932 Jan New York 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 1 ☐ Yes 2X No MD Baltimore Baltimore ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21220 USA 11 Tamarac Trail ral", or items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 Ayes 2 No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify Specify: White 152-56 "natural" 3 X Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation Decedent's Education 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hyglene. marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) the Ō conductor foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elwyn Koeppel Laura Nesslin of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Ballew/friend 11 Tamarac Trail Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of harmonic of harmonic line and injury or other any injury or other any injury or other and in 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛛 Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Raltimore, MD 21201 Ronald 23a. Part . Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Arteniosclenot Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of; signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detected. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? 1 Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Yes 2 🗌 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending 1 Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29d. Date signed (Month, Day, Year) 29c. License number November 12,2012 of person who completed cause of death (Item 23a) (Type, Print)

State

Month, Dav. Year.

NOV 1 9 2012

32. Registrar's Signature

e Trimble Hill CT. Latherville, Md 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 4 Physician/ 70 Medical Eacility Name (if not institution, give or Location of Death . County of Death Examiner WESINST LANUEL Age on yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Min. (Month 1 Day, Year) 920 1 M 2 X F Months Hours 92 Aug Director 178-12-1266 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA 2525 W. Belvedere Avenue unk 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. unk ģ 1 Never Married 2 Married ☐ Yes 2 ☐ No 21215-0036 1 ☐ Yes 2 🔀 No Specify: black If Yes Give Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 15 Decedent's Education unk 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If Item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blue Point Nursing & Rehab Ctr Belvedere Avenue Baltimore, other 1 2525 W. MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If It 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) in State injury or in state State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 re Harral S. vic Licensee Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause in each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consumence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death ed by the a detached f Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de þ Records, 2 00 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 [မ Nursing Home 5 Residence 6 C Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of De th Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Suiciae
Homiciae 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (M and address of person who State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Day 8 Physician/ 0604 2012 Mark Bryan Kessler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospita Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Oct 16, 1 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Funeral 1 💢 M 2 🗆 F Min. Months Days Hours Mary land 1960 Director 214-72-7430 Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director 1 ☐ Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ō an "natural", or items 23a or Medical Examiner must be Funeral 5302 Hamlett Avenue 21214 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian. Armed Forces? 1 Yes 2X No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: white Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry alth and Mental Hygiene. 27 is marked other than "r er traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) unk unk mechanic automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Lindbergh Kessler ELizabeth Annetta Schnattner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene Liske/sister 152 Black Oak Trail Delta, PA 17314 Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signal of Funeral Strvice Licenses 22. Name and Address of Facility State Anatomy Board 655 W, Baltimore Street Baltimore, MD 21201 Director en 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ liver tailure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner stage liver disease Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Examiner hepatitis Band hepatitis Cintection Cause (Disease or iinjury that initiated events resulting in death) Last veavs attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No been signed by the atter Month Dav Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ chronic osteomyelitis thrombocytopenia, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an ischemia autopsy performed Yes 2 has page 2 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred iniury Natural 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

24 hours after death. Funeral Director: After this completed within 2 To the F

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 🗆 29b. Signature and title 29c. License number 29d. Date signed (Month. Day, Year) RES 000 November 08, 2012

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601 Loch Raven Blvd Baltimore, MD tani Attman

State Registrar

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CORINNE KAPLAN NOVEMBER 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE JOSEPH MEDICAL CENTER If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Min. Director 078-18-2871 1 M 2 X F 88 07/07/1924 NY Usual Residence of Decedent Item 27 is marked other than "neture!", or items 23e or 28a-f show other treumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 111 WEST ROAD, #303 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 √ Widowed 4 □ Divorced Specify: Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER 12 OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Pege 1 end 2 should be filed trent of Heelth end Mental H rtent: If Item 27 is marked of မ **GREENBERG** DOROTHY SILVERMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6300 SHELRICK DRIVE, BALTIMORE, MD BARBARA BASS/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Importent: If It any injury or of cemetery, crematory or other place)
ARLINGTON CHIZUK
AMUNO CEMETERY 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/16/2012 BALTIMORE, MD 21. Signatury of Funeral Service Lionnsee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DAY Immediate Cause (Final Physician/ RESPIRATORY FALLUKE disease or condition Medical resulting in death) Due to (or as a consequence of): Examine DEMENTIA YEAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine ending physician and use as the burial-transit YEARS Hospital or Attending Physicien: The lew requires that the death certificate be executed MYASTHENIA GRAVIS Due to (or as a consequence of): resulting in death) Last sate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HIRPARA, M.D. 7601 OSLER DRIVE TOWSON, MD 21204 State NOV 19

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-08428 State of Maryland / Department of Health and Mental Hygiene Gene Autry Little 1- For State Certificate of Death Reg. No Registrar 2 Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 6, 2012 1825 hrs Gene **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2303 Pentland Drive # 305 Baltimore 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreian Months Hours Days Director -18-1930 Country) 214-38-2405 1 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Parkville or items 23a or 28a-f show must be notified at once. MD Ba 140 imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Hp+ 303 SA Pentland Drive 305 21234 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, is marked other than "natural", or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 1 Yes Black Specify: 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes. Give Year event, the Medical Examiner à 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Telephone Co. Elementary/Secondary (0-12) College (1-4 or 5+ 2th 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John ari 1aul au 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ၉ 19a. Informant's Name/Relationship (Type, Print) Part villa ntland 2/236 Wa If item 27 Jay 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State tment (Forest 29-2012 aumison Donation 5 Other Specify 6 22. Name and Address of Facility 21. Signalure of Funeral Service Licensee 10, 21202 Quenue 23a. Part/I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician tween Onset and failure. List only one cause on each line /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transi Physician/Medical UNPENDED **AMENDED** 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? 1 🗸 Yes Yes 2 No 2 No 25. Was case referred to medical 26 Place of Death (Check only one) Be director Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 🗹 Other: Scene 2 ER/Outpatient 3 DOA After this 1 Yes 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred the funeral 27 Manner of Death Certification: 1 V Natural 1 Yes 2 No 5 Pending within 24 hours after death.

To the Funeral Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 7, 2012 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			, POF	partment of Health and Me ertificate of Death	ental Hygier Reg. t	21112 37147		
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death		
	Physici /Medic		Lisa Lollis	1	November [13, 2012 6:54 A M		
)	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
			Future Care Canton Manor	Baltimore		NA		
	Funeral		5. Social Security Number $214-94-6573$ 6. Sex 1 \square M 2X \square F 7. Age (In yrs. last birthd) 7. Age (In	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)		
	Director		Usual Residence of Decedent		09-04-65	MD		
	how		10a. State 10b. County 10c. City, Town or			10d. Inside City Limits		
	8a-fs	cto	MD NA Baltim			XXYes 2 □ No		
	with the	by Funeral Director	904 Whitelock Street Apt. #1	10f. Zip Code 21217	10g. 6	Citizen of What Country? USA		
	leath	eral	11 Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ify Yes or No-	14 Dags American Indian		
9	after or Iter	Fu	Never Married 2 Married 1 ☐ Yes 2 No	If Yes, specify Cuban, Mexican, Puerto R 1 Yes 2 No Specify:	lican, etc.)	Black, White, etc. African		
903	urai',		3 Widowed 4 Divorced If Yes, Give Year or Dates:			Specify: American		
<u>.</u>	filed within 72 hours after death with the Maryland Hygiene. Hygiene "natural", or Items 23s or 28s-f show ther than "natural", or Items for notified at ant, It's Medical Example at must be notified at	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ve kind of work done during most of working DO NOT use retired)	g 16b.	. Kind of Business/Industry		
212	d withi	ошр	Elementary/Secondary (0-12) College (1-4or 5+) "" 5th Grade NA	Domestic		Home maker		
b	e filed al Hyg I othe vant,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name				
ltimore, Maryland 21215-0036	ould to Ment Ment arkec	To	William Lambert	Loveeda		Lowery		
Mar	12 sh h and 7 is m traum			illing Address <i>(Street and Number or Rura)</i> 4 Whitelock Avenue <i>A</i>				
<u>6</u>	Healt Healt tam 2		20a. Method of Disposition 20b. Place of Di	position (Name of Da	-	. Location - City or Town, State		
OE.	Pages lent of nt: If i		1 Burial 2 Xi Cremation 3 Hemoval from State	rematory or other place) Crematory 11-15-	-12 C	Catonsville, MD		
alti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic avent, Ite Medical Exercities must be rediffied at once.	П	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Wy]	lie Funer	al Home P.A.		
<u> </u>	89 = 9		Edemola Templan	638 N. Gilmor Street				
	36	W 3	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death		
1-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	Cancer				
	Examiner							
	p i	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury					
	ecute and I-trans							
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	alE	Due to (or as a consequence of):					
687	ifficate g phy: as the	edic	0.					
XOX	eath certific attending p for use as I	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery Month Day Year		
O. B	ne dea the at hed fo	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ Nee 9 □ Unknown 1 □ Yes 2 □ Nee 9 □ Unknown	5 Other (specify)		Month Day Year		
<u>.</u>	that the de ed by the detached	/ Ph	Part II. Other significant conditions contributing to death but not resulting in th	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?		
ds	w requires that been signed t should be det	d by			1 🗆 Yes	2 No 3 Probably 4 Onknown		
ecords,	law rec as bee 2 shou	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
	ician: The lav certificate has rector, page 2	Com			performed	? death?		
Vital	cian: ertific actor,	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)			
	Physi this c	10	1 ☐ Yes 2 ☐ 1 ☐ Inpatient 2 ☐ ER/Outpa 27. Manney 1 Death 28a. Date of Injury 28b. Tim		e 5 Residence	6 Other (Specify)		
u O	Attanding Physician: r death. ector: After this certifics by the funeral director.	tlon	1 Natural 5 Pending (Month, Day Year) Injur		ba. Describe now ii	injury occurred		
Division of	or Attanding I after death, Director: After in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	street, factory, office	8f. Location (Street City or Town, St	t and Number or Rural Route Number,		
	tal or A	Cert	4 Homicide building, etc. (Specify)		Ony or 701111, 51			
	To the Hospital or Attanding Physician: The withing thours after death. To the Funaral Director: After this certificate h completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) On	eath occurred at the time, date and place, are investigation, in my opinion, death occurred	nd due to the cause d at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)		
	To the within 2 To the complet	Mec	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. l	Date signed (Month, Day, Year)		
•	FSFO		11/15/12	D00700	76 11	15/12		
	y.		30. Name and a ress of person who completed cause of death item 23a) (Ty	pe, Print)	501			
			31. Date filed (Month), Day, Year) 32 Registrar's Signature	RUSH LOU,	would	W1W17-17374		
	Sta Registr		NOV 1 9 2012	arkel				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month D Day Physician/ 0327 AM Joan Marianne Langley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Lorien Mays Baltimore Chapel. Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Country) Hours Min 1 M 2 V F Director 216-05-8708 94 May_ 1918 Marvland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 2243 Wonderview Road USA 12. Was Decedent Ever in U.S.
Armed Forces2
1 ☐ Yes 2 ⚠ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: white Specify: Completed 3 Widowed 4 N Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 secretary electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Adam Bialczak Victoria Izdebski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jay Weitzel/nephew 2243 Wonderview Road Timonium, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 Other (Specify) Signature of Funeral Service Roma 1 ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ADULL Dement: A Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b, Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown page 2 should be detached for Month Day Year Pregnant at time of death the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completed filled in by the funeral director, To Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury a Certificate: 1 Natural 5 Pending work s after death. 1 Tes 2 🗌 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d Date signed (Month, Day, Year) 4101 Print) N Chastes 30. Name and address of p

State Registrar

			Please	Type or Pri							.egible.	
			For State	State of Ma	-		ment of H icate of D		Mental Hy	2	012	2711.1.
			Registrar 1. Decedent's Name (First, Middle, Las	st)		Jerun	icale of L	eau i	2. Date of De	Reg. No.	UIZ	3. Time of Death
	Physicia Medic		Genevieve Lipa						Month October	31.	2012	4:45 PM M
	Examin		4a. Facility Name (if not institution, give	street and number)		4t	o. City, Town, or	Location of Deat	h		ounty of Death	
THE ST			2300 Dulaney Va									
	Funeral Director			ex 7. Age	e (In yrs. last birthe		Under 1 Year onths Days	If Under 24 Hrs Hours Min.	(Month, Da	y, Year)	Count	lace (State or Foreign try)
			Usual Residence of Decedent		<i></i>				July 9	, 1915		-
	ryland -f sho ied at	ctor	10a State 10b County MD Baltim	0.000	10c. City, Town						1	0d. Inside City Limits 1 ☐ Yes 2√ No
	or 28a	Director	MD Baltim 10e. Street and Number	ore	111	oniu	0f. Zip Code			10a Citizer	n of What Coun	
	with the 23a cast be	Funeral	2300 Dulaney Val	lev Road				1093		•	SA	
	leath items ier mi	Fun	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was	Decedent of His		pecify Yes or No-		Race - Americ	
36	after (Il", or xamir	d by	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	1 ☐ Yes 2X If Yes, Give	No		Yes 2X No		to mount otoly	Spe	Black, White, e ec <i>ify:</i> whit	
21215-0036	hours natura lical E	Completed	15. Decedent's E				's Usual Occupa			16b. Kind	of Business/Inc	dustry
218	iin 72 e. nan "r	duc	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4 or 5		Give kind fe. DO N	of work done di OT use retired)	uring most of wo	rking			,
7	d with dygier ther t	Be C	12 17. Father's Name (First, Middle, Last)	0		bea	auticiar				smoto1o	gy
and	be file ental h ked o c eve	10 E	Matthew Lipa						me <i>(First, Middl</i> e, S ersen	Maiden Suri	name)	
ary	nould Ind Me s mar umati	8	19a. Informant's Name/Relationship (7)	ype, Print)	19b.	Vailing A	ddress (Street a		ıral Route Numbe	er, City or Tov	vn, State, Zip C	Pode)
Σ	ealth a n 27 i		GEnie Wessel/dau	ghter	10	517	Catters	skill Co	urt Col	umbia	, MD 2	1044
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 C	Removal from State	20b. Place of I cemetery		n (Name of ry or other place	e)	Date	20c. Locat	tion - City or To	wn, State
<u>Ħ</u>	it. Pag rtmen rtant: njury		4 🗓 Donation 5 🗆 Other (Special									
Ba	permi Depar Impor any ir	9	21. Signatu Ronald S	Dir.	ector	Sta	me and Addres te Anato timore,	omy Boar	d ₁ 655 W	. Balt	imore S	treet
Н			23a. Part 1 Enter the disease, or com shock, or heart failure. List only o	plications that caused		enter th	e mode of dying	, such as cardiad	or respiratory ar			Approximate Interval Between
	Phytician/	8 1	Immediate Cause (Final disease or condition	EN	D STA	AGE	DE	MENT	$\supset A$			5 That and the all the
مريب	Medical Examiner		resulting in death)	Due to (or as a	consequence of	:						1
		Jer	Sequentiary list conditions, if any, leading to immediate	b. Due to (or as a	consequence of							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.									
	executed an and urial-transi	al Ex	resulting in death) Last	Due to (or as a	consequence of	•						
9	ate be	edic		d	·							
P.O. Box 68760	iath certificate be executed attending physician and for use as the burial-transit	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						230	I. Date of delive	erv
30X	e atte	sicia	in the past 12 months? 1 ☐ Yes 2 🗷 No	1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death time of death	3 ☐ Ec 5 ☐ Ot	topic pregnancy her (specify)	у				Day Year
0	it the o	Phy	9 Unknown \Part II. Other significant conditions o		rt not reculting in	the under	shing souse give	on in Dart I	00 8:11			
	requires that the des been signed by the s should be detached	d by	CONGES		IFARI	F	AILUI	CE.	23e, Dia t	\ \		e cause of death?
Division of Vital Records,	requi been shoul	Completed			1071				24a, Was			osy findings available
Sec.	nysician: The law nis certificate has I I director, page 2 s	omp							auto	osy ormed?	prior to cor death? 1 ☐ Yes	npletion of cause of
a	sician: The certificate irector, pag	Be C	25. Was case referred to medical examiner?				26. Pla	ice of Death (Che	1 🗌 Yes	2 No	i Li fes	2 110
\equiv	Physic this ce	욘	1 🗆 Yes 2 🔀 No		ent 2 ER/Outr			4 Nursing I	Home 5 Resi			
n 0	tal or Attending Physis after death. al Director: After this ed in by the funeral d	Certificate:	27. Manner of Death 1 Natural 5 Pending	28a. Date of injur (Month, Day		ıry	28c. Injury work?	at ? Yes 2 🗆 No	28d. Describe h	now injury oc	curred	
Sio	Atten	rtiţi	2 L*Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Inju				163 2 110			umber or Rural	Route Number,
<u>></u>	tal or irs afte al Dire led in		- Control Control	building, etc	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Street and Number of Rural Route Number of Town, State)							
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Medical	(Check 2 Medical Exami		amination and/or	nvestigati	on, in my opinior	n, death occurred	at the time, date a	and place, and	d due to the cau	se(s) and manner stated.
	Fo the vithin to the comple	Ž	only one) 3 ☐ Certifying Nurs 29b. Signature and title of œrtifier	se Practitioner: To the		edge, dea	th occurred at the 29c. License		place, and due to		and manner as s igned (Month, L	
			> quotines	Theis	CRNP		ROY	13580		11-	1-2	012
	•		30. Name and address of person who o									`
	Stat		JUSTINE PREIS, 31. Date filed (Month, Day, Year)		2300 DU.	LANE'	Y VALLE:	Y KOAD	TIMO	V L U M	MD = 2	1093
	Registra	ar	31. Date filed (Month, Day, Year) NOV 1 9 2012	32. Registra	p. 19	The same of the sa						
DHV	VIH 17 Rev 06-2	011										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ NO V 35 ero 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death OREST HAVEN BALTIMORE NURSING HOME ATONSVILLE 7. Age (In yrs. last birthday) If Unde Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours (Month, Day, Year) Director 152-12-3657 1 🕅 M 2 🗆 F Mar 9, 1925 87 New Jersey Usual Residence of Decedent 28a-f show 10c. City. Town or Location 10d. Inside City Limits be notified at Director 1 X Yes 2 No MD Baltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 'A Health and Mental Hygiene.
'Health and Mental Hygiene.
'item 27 is marked other than "natural", or items 23a Funeral 2531 Old Frederick Road 21229 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 24 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white 3 X Widowed 4 Divorced Specify: Completed 15. Decedent's Education un 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) serchant seaman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Pause Robert Leroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Robert Leroy/son Old Frederick Road Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director my Put 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest short, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acuta disease or condition AVTE Medical resulting in death) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ detached for in the past 12 months? Month 2. No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death?
1 Yes 2 No perform The Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury work? Division Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar

hn 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Forest HavenNursing Mome Catonsville, Md

00033330

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1 4 Day Dorothy Mae McCauley 2012 101 Jul Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Caton Manor Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Hours 214-60-4218 1 □ M 2 🕱 F **Director** 67 Yrs. 09/29/1945 MD Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director MD N/A 28a-f Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò er than "natural", or items 23a or the Medical Examiner must be Funeral 910 S. Hanover 21230 U.S.A. 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene, item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Force ρ 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: Black If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Herbert McCauley Nancy Mae Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine McCauley (Sister 910 S. Hanover Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion 11/23/12 Lansdowne, MD 21. Signature of Funeral Service License Josephes H. Brown, Jr. Funeral Home PA 2140 N. Fulton Ave. Balto., MD 21217 Lan 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onse and Death Immediate Cause (Final Physician/ OL Medical resulting in death) Due to (or a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to or as a consequence of): Exami Cause (Disease or injury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months
1 Yes 2 No or Attending Physician; The law requires that the death Month 5 Other (specify) sate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 (Xto. ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Medical Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: Al 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Hospital certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar NOV 1

PATIENT KNOWN AS DION MOORE

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			For State		State o	of Marylar		artment of F		Mental Hy	Ü	2012	37	11.7
Registrar 1. Decedent's Name (First, Middle, Last)							Certificate of Death			Reg. No U U U U U U U U U U U U U U U U U U				Death
	Physician/ Dion Alonzo Moore										Month Day Year NOVENBER 15 2012 6:50			
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	pow #	Ē	Usual Residence of D 10a. State 10	Decedent Ob. County		10c Ci	ty, Town or Loc	cation		12/01	/ 19	00	10d. Inside Cit	ty Limite
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	a or 2		10e. Street and Number			10f. Zip Code					10g. C	itizen of What Co	ountry?	
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28e-f show may hipty or other treumatic event, the Medical Examinar must be notified at once.	Completed by Fu	11. Marital Status 1 Never Married 3 Widowed 4	Armed Fo 1 ☐ Yes If Yes, Giv	Armed Forces? If \\ 1 ☐ Yes 2 🐼 No		Was Decedent of Hispanic Origin? (Specify Yes or I f Yes, specify Cuban, Mexican, Puerto Rican, etc.) I ☐ Yes 2 ☑ No Specify:				14. Race - Ame Black, White Specify: B			
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yla	uld be d Ment marke	ပ္	Anthony						Vonzel	la Moo	re			
Ma	2 sho lth and 27 is r treun		19a. Informant's Name Vonzella			er)				ural Route Number, City or Town, State, Zip Code) Rd. Baltimore, MD 21215				4.5
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Ē	Page ment cant: If		1 ☐ Burial 2 🔯 6 4 ☐ Donation 5 l	Cremation 3 ☐ ☐ Other (Speci	J Removal from fy)	State On	emetery, crem 1-Site	natory or other plac Cremate	ory 11/2	24/12	Ba	ltimore	e, MD	
Balt	permit. Depart Import eny Inj		21. Signature of Funera	al Service Licen	see	301.	. 22	Name and Address JOSEPH 2140 N	s of Facility Bro	wn, Jr				——— РА
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, F	Physician/		shock, or heart fa Immediate Cause (Fina	ailure. List only o	one cause on ea	ch line.	-	-	9, 00011 00 0010100	o. 100p. a.o. y a.			Interval Bet Onset and I	ween
	Medical Examiner		disease or condition resulting in death)	•		LMONARY or as a conseq	uence of):	OLISM						
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	ted nsit	Examiner	if any, leading to imme cause. Enter Underlyin Cause (Disease or inju	ng K	Due to (or as a conseq	uence of):							
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687	ertifice ding p	/Me	IF FEMALE:		23c. If yes, out	come of pregna	ancy				T			
Box 68760	death c	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown 1 Unknown 23c. If yes, outcome or pregnancy 1 Ectopic pregnancy 1 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9							Ī	23d. Date of de Month		/ear	
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ita	sicien: certific rector	Be	25. Was case referred to examiner? 1 ☐ Yes 2 ☑ N	,	Hospital:			Othe	ace of Death (Chec	ck only one)				
<u>\$</u>	a Physer this seral d	е: То	27. Manner of Death		28a. Date	Inpatient 2 of injury	28b. Time of	t 3 DOA 28c. Injury	4 ∐ Nursing H	ome 5 Resident		6 Other (Spec	rify)	
S	ending seth. or: Afte the fur	ficat	2 Accident	☐ Pending Investigation ☐ Could not b	n i	h, Day, Year)	injury	work M 1 □	? Yes 2 □ No		,,	,		
Division of Vital Records, P.O.	To the Hospital or Attending Physicien: The lew requires that the death certificete be within 24 hours after death. To the Lunerel Director After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but	al Certificate:	3 ☐ Suicide 6 4 ☐ Homicide	of Injury - At hong, etc. (Specif)	ome, farm, stre	et, factory, office			8f. Location (Street and Number or Rural Route Number, City or Town, State)			er,		
	Hosp 24 hou Fune etely fi	Medical	(Check 2 L.)	Medical Exam	iner: On the bas	is of examinatio	n and/or investi	ccurred at the time igation, in my opinio	 n. death occurred a 	at the time date a	and place	and due to the	cause(s) and mai	nner stated.
	To the within To the complete	2	only one) 3 ☐ 29b. Signature and title		se Fractitioner		пу кложіваде,	death occurred at the 29c. License		lace, and due to		e(s) and manner a te signed (Monti		
			K4			MD		RES	000		Nove	MBER !	5,2012	
	1		30. Name and address	_	completed caus		T1		D					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 4, 201^{rear} 8:10 AM M Margaret J. Metz Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Bel Air Harford 7 Linwood Court 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) Director 162-26-9100 1 🗆 M 2 🔯 F 1932 Sept 15, Pennsylvania or than "natural", or items 23e or 28a-f show 10b. Count 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2√☐ No MD Harford Bel Air 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7 Linwood Court 21014 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) el Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) teacher education t. Page 1 and 2 should be filed wit tment of Health and Mentel Hygie tent: If item 27 is marked other jury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Gordon Jackson Annie Edith Hitchon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Metz/spouse 7 Linwood Court Bel Air, MD 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State etery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) Signature of Funeral Second Kona K 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 ade Director 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day 4 Pregnant at time of death 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1 Yes 2 -No 1 Yes 2 1/10 Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, NOV 19

rson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 16 2012 1:03 November Roger Glenn McConathy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9829 Glenolden Drive <u>Montgomery</u> Potomac If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min (Month, Day, Year) 1 M 2 □ F **Director** 462-82-3969 <u>September 15, 1948</u> Usual Residence of Deceder or 28a-f shov 10d. Inside City Limits 10b. Count 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🕅 No Maryland Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20854 9829 Glenolden Drive United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Completed Year or Dates. Vietnam White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 12 Construction Procurement Vice President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Arthur <u>McConathy</u> Tommie Povner Malone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 20854 Catherine Kleynhoff/ Wife 9829 Glenolden Drive, Potomac Baltimore, 20b. Place of Disposition (Name of Mcematery crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State November 19, 2012 Lorium, Inc. 19, 2012 | Bethesda, Maryland

22 Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 4 Donation 5 Other (Specify) Crematorium, 21. Signature of Funeral Service Licenses M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Pancreatic Cancer Months disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause Fitter Indexying Cause (Disease or injury Exami Hospital or Attending Physiclen: The law requires that the death certificate be executed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2 No page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 🕅 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2 🖺 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 24 hours after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated University of the Cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) November 16, 2012 D0053284 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gray, M.D.4314 Montgomery Avenue, Bethesda, Maryland 20814 32, Registrar's Sig State

DHMH 17 Rev 06-2011

Registrar

			_ For		State o	f Marylaı	nd / Dep	artment of I	Health a	and M	ental Hy	giene ₂	012	37150
			State Registrar				Ce	rtificate of l	Death			Reg. No.	012	07:00
	Physicia Medic										November 11, 2012			3. Time of Death 3:11 P M
	4a. Facility Name (if not institution, give street and number) Suburban Hospital							4b. City, Town, o	r Location o	of Death			ounty of Death	
	Funeral Director		5. Social Security Number 577–62–9050	er 6. S		7. Age (In yrs. 65	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bird (Month, Da April 7	y, Year)	Cour	place (State or Foreign ntry) ington, D.C.
land	28a-f show otified at	tor		. County		10c. C	ity, Town or Lo							10d. Inside City Limits
he Mary	or 28a- e notifie	Director	Maryland Mo	ontgome	ery		Cł	10f. Zip Code	e 			10g. Citizer	n of What Cou	1 Yes 2 X No
th with 1	ns 23a must b	Funeral	8808 Altimo	ont Lai					0815				ed Stat	
036 rs after dea	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status1 Never Married 23 Widowed 4 I		12. Was Deced Armed For 1 X Yes If Yes, Give Year or Dat	ces? 2 No		Was Decedent of HI Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican	n, Puerto F	oify Yes or No- Rican, etc.)		. Race - Americ Black, White, ecify: W	
21215-0036 within 72 hours after	ın "natı Medical	Completed	(Specify o		ade completed)		(Give	dent's Usual Occup kind of work done OO NOT use retired)	during most	t of workin	g	16b. Kind	of Business/In	dustry
212 d within	lygiene. ther tha nt, the	Be Col	Elementary/Secondary		College (1-5+	4 or 5+)		fied Publ	Lic Ac				countir	ng
/lanc	Mental F arked of atic ever	To B	17. Father's Name (First, I Walter Ern		ncuso						(First, Middle, lerzog	Maiden Sun	mame)	
, Man	ealth and I n 27 is ma er trauma		19a. Informant's Name/R Joan L. Man					ing Address (Street Altimont						
Baltimore, Maryland	tment of He tant: If iter ijury or oth		20a. Method of Disposition 1 □ Burial 2 ☒ Cre 4 □ Donation 5 □	emation 3 C	fy)	State Mo	ntgome emator	osition (Name of matory or other place ium, Inc	•	Nov. 201	2	Bethe		aryland
Bal	permit Depar Impor any in		21. Signatur of neral	rvice Licens	see	M001	L98 7	2.Name and Addre Obert A. I 557 Wiscon	es of Facilit Pumphi nsin A	rey Fu	uneral Bethes	Home/ ^l da, Ma	Bethesd Chas iryland	a-Chevy e, Inc. 20814-3501
Ph	ysician/		23a. Part 1. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition	sease, or compure. List only o	ne cause on eac	ch line.	th. Do not en		ng, such as	cardiac or				Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	C	a	or as a consec							1	
70		niner	Sequentially list condition if any, leading to immediate Enter an entrying	ate	b. Due to (c	or as a consec	uence of):							
/ sxecute	hysician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last		c. Due to (c	or as a consec	quence of):							
/5/ 760 ate be	physicia the bur		d											
LSO, Waffer II/II/2 @151/ ision of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate be executed	been signed by the attending p should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregn in the past 12 month 1 Yes 2 No 9 Unknown	Iaiii		Birth 2 ☐ Fe: lant at time of	al death 3	Description of the Control of the Co	су			230	d. Date of deliv Month	rery Day Year
P.O.	gned by be detac	by Ph	Part II. Other significant		ontributing to de	eath but not re	sulting in the	underlying cause gi	iven in Part I	I.	23e. Did to	obacco use	contribute to t	he cause of death?
requires	been sig	eted	Diabetes								1 🗆			bably 4 Unknown
Her Reco	certificate has t lirector, page 2 s	Comp	25. Was case referred to r	madical							autor perfo 1 Yes	psy ormed?	prior to co death? 1 \(\sum \text{Yes}\)	empletion of cause of
Sa Vita	is certific director,	To Be	examiner? 1 🔀 Yes 2 🗆 No		Hospital:	nnationt 2 🕅	ER/Outpatie	26. P	lace of Deat		-	donos e \Box	Other (Specify	d
n of July	h. After this funeral d	ate: T		Pending	28a. Date o		28b. Time o injury	f 28c. Injur	v at	2	8d. Describe h			9
2 ≥ 5	i ji the	Certificate:	2 Accident 3 Suicide 6 4 Homicide	Investigation Could not be determined	e 28e. Place	of Injury - At h g, etc. <i>(Specin</i>		reet, factory, office	yes 2 🗆		8f. Location (S City or Tow		umber or Rura	l Route Number,
D D D Hospital	within 24 hours a To the Funeral C completely filled	Medical	(Check 2 M	ledical Exami	ner: On the basis	s of examination	on and/or inves	occurred at the time stigation, in my opinion, death occurred at	on, death oc	courred at t	the time, date a	and place, an	d due to the ca	use(s) and manner stated
To the	within To the compl	2	29b. Signature and title of	A A		in the pest of	my knowledge	29c. Licens		· A			igned (Month,	
			30. Name and address of	person the	ompleted cause	e of death (Iter	n 23a) (Type.	Print)	578	50		1111	11/20/2	,
2511			C VOICY 31. Date filed (Month, Day	W002	Brown 1811	SON	8-600	OLD bei	note	n Ro	d, se	thesd	4	
	Stat Registra	ᄃ		9 2012		gistrar's Sign	far	w						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 14 2012 SHIRLEY CARDIN MAGER 08:05A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 4730 ATRIUM COURT, #203 OWINGS MILLS 5. Social Security Number 7. Age (In yrs. last birthday) f Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 216-14-3071 1 □ M 2 🕅 F 96 08/15/1916 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at be filed within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2X No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4730 ATRIUM COURT, #203 21117 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE "natural", 3 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) SECRETARY LEGAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HARRIS CARDIN ANNA CHERRY permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EILEEN MAGER/DAUGHTER 106 RIVER OAKS CIRCLE, PIKESVILLE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 4 Donation 5 Other (Specify, BETH TFILOH CONG. 11/16/2012 WOODLAWN, MD Signature of uneral Senties Liceusee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ RINGL disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** CIF Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in 2 Cause (Disease or injury Examiner Due to (or as a consequence of) 03/7 the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant
9 Unknown Pregnant at time of death 5 Other (specify) signed by the sid be detached Yes Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\text{Yes} \) 2 \(\text{No} \) No 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a, Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioners to best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. - 2048Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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31. Date filed (Month, Day, Year) -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ = 554 M Warren Oliver Nice Tovemb 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1254 Masters Dr. Anne Arundel Arnold Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Country) 297-10-0008 Director 1 **XX**M 2 🗆 F June 25, 1913 OH 99 Usual Residence of Dec show the Maryland ms 23a or 28a-f sho must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No MD Anne Arundel Arnold 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1254 Masters Dr. items 2 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. ed other than "natural", or iter event, the Medical Examiner 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XX If Yes, Give XX Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 XXVidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and 2 should be filed within 7 Health and Mental Hygiene. tem 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Machine Operator Mechanical Mold & Machine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F ည Norman Nice Anna Wirth injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1254 Masters Dr., Arnold, MD 21012 Norman Nice Son permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3XX Removal from State cemetery, crematory or other place) Loyal Oak Cemetery Nov 10, 2012 4 Donation 5 Other (Specify) Norton, OH re f Funeral Service Name and Address of Facility
Fink Funeral Home, P.A. K. Gregory Fin Part 1. Enter the disease, o shock, or heart failure. List M01148 426 Crain Hwy S., Glen Burnie, MD 21061 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Physician/Medical law requires that the death certificate be P.O. Box 68760 phys. as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 Jas autopsy Hospital or Attending Physician; The performed death? this certificate Yes 2 No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ရ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral to 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 86 01 Veterans mo zuo NOV 1 9 2012 31. Date fi 2. Registrar's Signature State Registrar

Please Type of Print in Black Indelible lok-fineurs All Copies Are, Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Dorthy 2. Date of Death 3. Time of Death Newton Month Physician/ 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A **Funeral** . Age (In yrs 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 04/21/1924 Months 214-20-4759 Hours Country) **Director** 1 M 2 XF 88 rs. Virginia Usual Residence of Decedent or items 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director N/A MD Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1914 N. Fulton Ave. 21217 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: Black 3 Widowed 4 X Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Judge Theimulus Legal Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Floyd Wyche Elliott Viola Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlayna Mattews (Dghtr.) 1914 N. Fulton Ave. Baltimore, MD 21217 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State On-Site Crematory 11/20/12|Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens Josephes H. Brown, Jr. Funeral Home PA 2140 N. Fulton Ave. Balto., MD 21217 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician YA Medical resulting in death) Due to (or as a consequence of) Examiner 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the attending physician and ched for use as the burial-tran Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year g Unknown signed by det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy Yes 2 No perform this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ၉ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director, After Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifie (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year, he and address of person who completed car of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ November 15. 2012 June Popp 7:40pMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Stella Maris Dulaney Valley Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 342-16-6494 90 Director 1 □ M 2 🖺 F Jan. 13, 1922 Illinois permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once. 10h County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore Nottingham 1 🗌 Yes 2 🔀 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8618 Castlemill Circle 21236 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Bookkeeper Dept. of Aging Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frederick Lehmbeck Clara Franke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Popp (Niece) (Daughter) 8618 Castlemill Circle, Nottingham, MD. 21236 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
Loudon Park Cemetery 11/19/12 1 👿 Burial 2 🗆 Cremation 3 🗔 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Fark Funeral Home 3620 Wilkens Ave., Baltimore, MD. 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physiclan: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day 1 ∐ Yes 2 p 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined hours after City or Town, State) within 24 hours a To the Funeral D Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier R043580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD 31. Date filed (Month, Day, JUSTINE PREIS, CRNP 21093 TIMONIUM MDYear) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mont Physician/ 90 -20/3 7:20 PM a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Emeritus at Towson Towson 8. Date of Birth (Month, Day, March 18, 9. Birthplace (State or Foreign Country) Florida . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Social Security Number **Funeral** Months 1 🗆 M 2 🗶 F Hours 90 028-18-0210 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10b. County 10a. State Examiner must be notified at Director 1 Yes 2 No Maryland Maryland Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 0 10e. Street and Number Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b 21212 U.S.A. 6451 N. Charles Street Apt. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Deceded Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher 5+ years Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Gaudelet Miles Augustus Libbey Ethel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42856 Broadwell Ct. Ashburn, David Page (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State Forest Hills Cemetery - 11-24-12 4 Donation 5 Other (Specify) Boston, Massachusetts 21. Signature of Funeral Service Licensee Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line 20nset and Death 20/2 Immediate Cause (Final Playsician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has r this certificate har aral director, page 1 Yes Yes 2 26. Place of Death (Check only one) 25. Was case referred to nedical examiner? Other: 4 Nursing Home 5 Residence 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28c. Injury at work?
1 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural 2 🗆 No 2 Accider
3 Suicide Accident Investigation Could not be within 24 hours after death

To the Funeral Director: Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Médical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature ar 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

RMP

30. Name and address of person who completed cause of death (Item 23a

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Joseph Jackson Ам November Prevo 4:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 305 Mace Avenue Essex Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours (Month, Day, Year) Months 212 44 3163 66 Director 1 XM 2 - F Jan.20,1946 Maryland 28a-f show 10a, State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Baltimore Essex 1 Tyes 2 X No 10e, Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 305 Mace Avenue 21221 USA items ; . Page 1 and 2 should be filed within 72 hours after death unent of Health and Mental Hygiene. Fart: If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. b 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Parks & Recreation 12 Laborer Be Baltimore, Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ William Jackson Prevo Nettie Spence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Prevo (Wife) 305 Mace Avenue Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oti Date 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Meadowridge Mem. Park | 11/19/2012 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 21. Signature of Funeral Service Lice Maryland 21221 1407 Old Eastern Avenue Essex 23a Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Ptn/seciun/ Medical resulting in death) Due to (o as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trai Due to (or as a consequence of): ed by the attending physician detached for use as the buria Completed by Physician/Medical Hospital or Attending Physician: The law equires that the death certificate be east hours after death.

Funeral Director: After this certificate has been signed by the attending physicial. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe Records, cate has been sig ; page 2 should b 1 Tes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed After this certificate 2 🛛 N director, 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: ပ 1 Yes _2 X No To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending injury work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year, 404-406 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

en 31. Date filed (Month, Day, Year,

NOV 1

32. Registrar's Signatu

Essex, MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 per FH C933 11/19/2012
State of Maryland / Department of Health and Mental Hygiene

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Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	Hilling Al and A							
Director 217-58-6237 1 □ M 2X□ F 56 Yrs. Months Days	Hours Min. (Month, Day, Year) Country)							
	12/01/1955 MD							
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10f. Zip Code 2519 Park Heights Terrace 21215	10g. Citizen of What Country?							
Sula Hesidence of Decedent 10a. State 10b. County N/A Baltimore 10c. City, Town or Location Baltimore 10f. Zip Code 2519 Park Heights Terrace 21215 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hist	D.S.A. panic Origin? (Specify Yes or No-							
The property of the property o	, Mexican, Puerto Rican, etc.) Black, White, etc.							
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D P T T T T T T T T T T T T T T T T T T	Shoppers 18. Mother's Name (First, Middle, Maiden Surname)							
Claude L. Scott	Marie A. Tate							
19a. Informant's Name/Relationship (Type, Print) Carolyn M. Ames (Sister) 19b. Mailing Address (Street and Sister)	d Number or Rural Route Number, City or Town, State, Zip Code)							
20a. Method of Disposition 20b. Place of Disposition (Name of	aels Circle Odenton, MD 21113							
1 Donation 5 Other (Specify)								
21. Signature of Fugeral Service, Licensee	of Facility Brown, Jr. Funeral Home PA							
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CO Cage had a contract to the	autopsy prior to completion of cause of death?							
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27. Mann or of Death 1 Matural 2 Accident 3 Suicide 4 Homicide 28a. Date of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year) 28c. Injury at work? 1 Matural 28c. Injury at work? 1 Metural 28c. Injury at work? 1 Metural 28c. Injury at work? 1 Metural 28c. Injury at work? 28d. Place of Injury - At home, farm, street, factory, office	28d. Describe how injury occurred							
building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Section Proceedings Proceedings Procedure Pr								
(Check only one) (Check one) (Check only one)	leath occurred at the time, date and place, and due to the cause(s) and manner stated. me, date and place, and due to the cause(s) and manner as stated.							
29c. License nun	mber 29d. Date signed (Month, Day, Year)							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	30 10 1/0 13 201Z							
The and address of person who completed cause of death (Item 23a) (Type, Print)								
State Begistrar 31. Day 11/Mong D2017 Begistrar 32. Registrar's Signature	Blud Oleh Busen 2106/							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 910 2017 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death BATIMOTE HOCKITAL JE60016 If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 09-05-50 Country) 62 Director 223-78-6375 VA 1 **XX**M 2 □ F Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director notified MD NA Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a r must h be 21216 Funeral 1103 Wheeler Avenue items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. "natural", or ite Black, White, etc. African Armed Forces?
1 ☐ Yes 2 🗓 No þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: 3 Widowed 4 Divorced Specify: American Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Bob's Auto Shop traumatic event, the 12th Grade Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental H fitem 27 is marked of ပ္ Coleman Hiland Robinson, Sr. V. James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Kentbury Court Owings Mills, Maryland 21117 Linwood C. Robinson-Brother Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 Department of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11-19-12 Catonsville, MD Metro Cremation 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a co Ful Mongry Dis rate the Hospital or Attending Physician; The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23h. Was decedent pregnant 23d. Date of delivery be detached for in the past 12 months? Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available After this certificate has prior to completion of cause of death? 1 Yes 2 No 1 Yes director. Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 LI No 1 Yes Other: ပ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work?
1 Yes 2 No 5 Pending Investigation Director Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d, Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

Name and address of person who

9

Date filed (Mor

2000

d cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 31 per dvr 9933 11-19-12 vt. State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEM BELL Day Physician/ Jewel C. Richburg Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltinde N/A ISAL II MORE HOSPITAL OF 8. Date of Birth (Month, Day, Year, 1 1 / 3 0 / 5 8 Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 7. Age (In *yr*s. 53 **Funeral** Days Hours Months 214-72-8014 Director 1 □ M 2 🏖 F Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Baltimore 10d. Inside City Limits 10a. State Director N/A MD 1 X Yes 2 ☐ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 2215 N. Popular Grove st. 21216 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. frican ecity: Armed Forces?

1 Yes 2 XNo 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed 4 Divorced Amer. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Rite Aids Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Manager æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elijah Baker Jean M. Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maurice Day/Husband 2215 N. Popular Grove st., Balt., MD 21216 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 Removal from State 11/19/12 Balt., MD Bayview Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facilit Hari P. Close F. Svs. PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Juneral Servic Licensee 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ŧδ etaskal disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes မ 1 Plnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 👱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier RES-000 2017 30. Name and address of person who compléted cause of death (Item 23a) (Type, Print) 2401 West MARS 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James Milton Smith 2012 3:25 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore Future Care N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 219-62-5464 1 🕅 M 2 🗌 F 57Yrs 06/04/1955 MD per nit. Pege 1 and 2 should be filed within 72 hours efter death with the Merylend Det artment of Heelth and Mentel Hygiene.
Imprortent: If Item 27 is merked other then "neturel", or Items 23e or 28a-f show amy injury or other treumetic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MDN/A Baltimore 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1426 Riggs Ave. 21217 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces ģ 1X Never Married 2 ☐ Married Black, White, etc. 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Divorced If Yes, Give Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Worker Construction 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Milton Smith, Sr. Ruth Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nekia Smith (Daughter) 1426 Riggs Ave. Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Durial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) On-Site Crematory 11/21/12 Baltimore, MD 21. Signature of Funeral Service License ²² Name and Address of Facility
JOSeph H. Brown, Jr. Funeral Home PA <u> 2140 N. Fulton Ave. Balto., MD 21217</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a nursequence of) ettending physician end i for use es the buriel-transif The law requires that the deeth certificete be executed Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the eight Id be detached for g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has b il director, pege 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☑ No for Attending Physicien: efter death. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No a 26. Place of Death (Check only one) Hospital Other: 4 Mursing Home 5 Pesidence 6 Other (Specify) Certificate: To After this c 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 D Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and blace, and due to the cause(s) and manner estated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) PHYSICIAN 11-13-19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEETINDER SANDHU 1940 W, BALTIMURE ST, BALTIMORE, MD 21223 mn 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year AM 09:14 Medical Vovember Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Johns 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs . Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 218-58-8839 **Director** 1 □ M 2 □ F MD 60 Feb. 13, 1952 Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov er than "natural", or items 23a or 28a-f shov , the Medical Examiner must be notified at 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 530 N. 21205 USA Chester St. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) llth Disabled N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Herbert Smith Frances Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $530\ N.\ Chester\ St.\ Balto, Md.\ 21205$ (Friend) Ellwood Harris or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it 1X Burial 2 Cremation 3 Removal from State King Memorial ParkNov.21,2012 injury Balto, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Calvin B. Scruggs Funeral Home Preston St. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed when cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? After this certificate ☐ Yes 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier within 24 hou To the Funel completely fi (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certific 29c. License number

State Registrar 30. Name and address of f 4n+mon

31. Date filed (Month, Day

NOV 1

who completed cause of death (Item 23a) (Type, Print)

800

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1 Day Nov. 2012 6:25a Edward Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospice Dove House Westminster Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** May 4,1928 Min. Virginia Director 217-24-7693 1 X M 2 🗆 F 84 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "netural", or Items 23e or 28e-f show any hjury or other treumatic event, the Medical Examiner must be notified at once. il Hygiene. other then "netural", or items 23e or 28e-f show vent, the Medical Evarriner raust be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3860 Normandy Dr. Apt. 21074 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 1 Types 2 □ No If Yes, Gives 1 − 1953 Year of Dates.1 Black, White, etc. 1 Never Married 2 Married ঠ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖸 No Specify: Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4 or 5+) 10 Fire Fighter Fire Dept Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Smith Betty Lapinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21074 3860 Normandy Dr. Apt. 1A Hampstead, MD. Mary C. Smith - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Evergreen Mem. Gardens Finksburg, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityEckhardt Funeral Chapel P.A. Eshardt 3296 Charmil Drive, 21102 Manchester, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a convequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mjury Due to (or as a consequence of) Exami Hospitel or Attending Physicien: The lew requires that the death certificate be executed ettending physicien and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year 24 hours after death.
2 Funerel Director. After this certificate has been signed by the eletely filled in by the funeral director, page 2 should be deteched. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed?' Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) K No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Deat Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work? Accident Investigation 3 Suicide 4 Homícide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month) Day, Year)

Registrar DHMH 17 Rev 06-2011

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

31. Date filed (Month, Day, Year)

NOV 1

-10102

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November Mary Seibert Edna 2012 4:15 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlestown Care Center Catonsville Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Country)
Maryland Director 216-09-2518 1 □ M 2 🗓 F Dec. 24, 1914 Yrs. ir than "neturel", or itams 23e or 28e-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours aftar death with the Meryland Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 TNo MD Catonsville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 USA 717 Maiden Choice Ln., ST122 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiena. I other then " College (1-4 or 5+) Elementary/Secondary (0-12) 12 Senior Clerk Bendix Corp. parmit. Paga 1 and 2 should be filled w Department of Heelth and Mental Hygi Importent: If Itam 27 is marked otha any injury or other traumetic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Dobeck Thurease William Salchonas 5 4 1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Weinkam. Sr. Per. Rep. 1002 Frederick Rd., Catonsville, MD. 21228 20a. Method of Disposition 20b. Place of Disposition (Name of Balting repair Creater of Control of Contr 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/16/12 Baltimore, Maryland . Signature of Funeral Service Liversee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and complately filled in by the funeral director, page 2 should be deteched for use es the buriel-transit Cause (Disease or injury that initiated events resulting in death) Last tha Hospitai or Attanding Physician: The lew requires that tha death certificate be exacuted Due to (or as a consequence of): To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Ves 2 No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M. Bitterword CRAP 11-15-12 R082382 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709 Maidenahoice Came Baltimere md 21228 CKNP State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Earl W. Strain, Sr.	1- For State Registrar	State of Maryla		ent of He ate of De			eg. No. 20	2 3716
Physician/	1. Decedent's Name (First					Date of Dear Month	th Dav Year	3. Time of Death
Car Examiner	nail w	Villiam Str	ain, Sr.	I 4h C	ty, Town, or Location o	November	10, 2012 4c. County of D	2050 hrs
		General Hospital			lumbia	, Double	Howard	saur
Funeral	5. Social Security Number	er 6. Sex	7. Age (In yrs. last birt		Under 1 Year If Under		th(MM/DD/YYYY) 9.	Birthplace (State or
Director	213-14-5316	5 1XXM 2 F	90	Yrs. M	onths Days Hours	Min. 12-23	-1921 F°	reign Country) MD
è	Usual Residence of Dece 10a. State 10b. C		10c. City, Town	or Location				10d. Inside City Limits
how a	\ \mathrea{1}	Howard	roc. oxy, rown	Of Eccation	E1kri	dao		1 Yes 2 X No
the Maryland a or 28a-f sh tified at once Director	10e. Street and Number	loward		10f	Zip Code		og. Citizen of What C	
the Marined	6249 Montgo	omery Road			21075		United S	tates
r death with the Maryland or items 23a or 28a-f show any imust be notified at once. Funeral Director	11. Marital Status 1 Never Married 2		edent Ever in U.S.	13. Was Dec	edent of Hispanic Orig pecify Cuban, Mexican,	in? (Specify Yes or No	- 14. Race - Ar White, etc	nerican Indian, Black,
er dear , or it	3 X Widowed 4	1 Yes	2 X No			r deno Rican, etc.)	,	White
urs aft tural" amine		Divorced If Yes, Give Year or Dates: on (Specify only highest grad			2 No specify: ual Occupation (Give k	ind of work done	Specify: 16b. Kind of Busine	
5-0036 ed within 72 houn fygiene. other than "natu the Medical Exan Completed	Elementary/Secondary			during most of	working life. DO NOT	use retired)	100.74.70 07.500.70	oo,daba y
within iene. er tha	12			Car	rpenter			truction
215-0 be filed and Hyg rked other ent, the	17 Father's Name (First, I				18.Mother's	s Name (First, Middle, N Alice Ball	faiden Sumame)	
212 nould be d Ment is mark tic ever	19a. Informant's Name/Re		198	o. Mailing Add	ess (Street and Numl	ber or Rural Route Num	ber, City or Town, Si	ate, Zip Code)
MD d 2 sho lth and lth and umat		A. Lowe - dau	ghter 5	007 Lai	nding Rd.,	Elkridge,		
ore, sslan of Hea If iter	20a. Method of Disposition 1 X Burial 2 Cre	n emation 3 Removal fro		of Disposition (ory or other pl	Name of cemetery, ace)	Date	20c. Location - City	or Town, State
LimC Page ment tant:	4 Donation 5 Of	ther Specify:				11-14-2012	-	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	21. Sign, ture of Funeral S	Service Licensee	0					neral Home at
Physician	23a. Part I. Enter the disea	ase, or complications that ca	aused the death. Do no					ge, MD 21075 Approximate Interval
/Medical Examiner	failure. List only one Immediate Cause (Final d	Ob. 1.1.	a food bolus					Between Onset and Death
Examiner	or condition resulting in de		consequence of):	·	-	-		
- La	Sequentially list conditions if any, leading to immediate		consequence of):	-				
mim ri	cause. Enter Underlying (Disease or injury that initial	Cause c	2011				·	
uted d ansit	events resulting in death)	Last Due to (or as a	consequence of):					
60, the be executed tysician and e burial - transit Aedical Examiner	UNPENDED	AMENDED			.			
760, icate be physici the buri	IF FEMALE: 3b. Was decedent pregna		outcome of pregnancy				23d. Date of deliv	very
Box 687/ c death certifice the attending pi of for use as th	past 12 months?	I Live bi	rth 2 ant at time of 5			pregnancy	Month	Day Year
Box 6876. The death certificate the attending phy hed for use as their Physician/M	1 Yes 2 No 9	Unknown 9 death Unkno		Other (specify)			
Records, P.O. Box 687(i.e. The law requires that the death certifical fifcate has been signed by the attending ptr, page 2 should be detached for use as the Completed by Physician/M	Part II. Dther significant		death but not resulting	in the underl	ing cause given in Par			to the cause of death?
ds, F quires en sign uld be ted	Cardiac vascula							Probably 4 Unknown
COrc lawre has be 2 2 sho nple	Atrial Fibrillation	1		-		24a. Was a autop: perform	sy prior	autopsy findings available to completion of cause of
ificate cor	Femur fracture 25. Was case referred to n					1 Yes 2	No 1	Yes 2 No
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the repeated that the state death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P	examiner?	Hospital:	npatient 2 ER/Ou	utpatient 3	26.Place of Death (C		Residence 6 Ot	her:
of N ng Phy After ti uneral n: T	27. Manner of Death	28a. Date of (Month), Nov 10, 2		Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred	
ttendi death. stor: / the fi	1 Natural 5 2 ✓ Accident	Pending Nov 10, 2	2012 1245	hrs	1 Yes 2 🗸 I	No Subject fell a	and later choked	on a food bolus
Division of Vision of Vision of Attending Physical or Attending Physical Director: After this filled in by the funeral differential contribution: To	3 Suicide 6	Could not be 28e. Place	of Injury - At home, fa		ory, office building, etc.			Rural Route Number, City
lospita hours unerally fille	4 Homicide 29a. Certifier	(0,000.19)	Rehabilitation Fa				ate) ton Blvd, Elkridge	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transis Medical Certification: To Be Completed by Physician/Medical E)	one) 2 ✓ Medica	ying Physician: To the best al Examiner: On the basis o and manner st	f examination and/or in	ith occurred at ivestigation, ir	my opinion, death occi	ce, and due to the cause urred at the time, date a	e(s) and manner as s and place, and due to	tated. the cause(s)
Ne state	29b. Signature and title of		ateu.		29c. License number		29d. Date signed (i	Month, Day, Year)
	- 1/	//(_			O.C.M.E.		November 16,	2012
OCME		person who completed cause		000.141	Dolling Ci	Dalkina - Na sa	200	
State	Mary G. Ripple M 31. Date filed (Month, Day,		ledical Examiner	900 W. I	saltimbre Street, l	Baltimore, MD 21:	223	
Registrar		9 2012		ule)				
DHMH 17 Rev 1/2001 OCME 2006		Johnson	OR	IGINAL		· · · · · · · · · · · · · · · · · · ·		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 11cm 10c per fh g933 11-19-12 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of De 2. Date of Death Physician/ Month NOVEMBER stevenson 00.45 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. Gounty of Death HOSP ITAL BALTIMORE OF BALTIMORE 5. Social Security Number 213 20 7625 If Under 1 Year If Under 24 Hrs Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) **Director** 1 □ M 2 🗷 F N.C Usual Residence of Deceden item 27 is marked other than "neture!", or items 23a or 28a-f show other treumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1. Yes 2 No MD allo **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2102 U USA 21 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married PAULINE STEVENSON Baltimore, Maryland 21215-0036 and Mental Hygiene. is marked other than "neturel", or ģ be filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) eath Care Assistant æ 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) မှ Hattie inomoson unk. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address, (\$treet and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 sh Department of Health ar Importent: If item 27 is eny injury or other treu reraldine oti 23150 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sw Set Lemetery 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State -20-12 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Comsecutive 22. Name and Address of Facility 2 40 Fredhilton Pass Balto. MD alaza 23a. Part 1 Enter the disease, or complications that caused shock or heart failure. List only one cause on each line. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ RESPIRATORY ACIDOSIS disease or condition resulting in death) ODAYS Medical Due to (or as a consequence of): Examiner 12 DAYS HEALTH CARE ACQUIRED PHEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examin ettending physician end for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 9 Unknown signed by the e id be detached f 9 Unknown <u>Р</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY Records, HYPERTENSOON ARTERY cate has been sig ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 autopsy performe 1 Yes 2 No 1 ☐ Yes 2 ☑ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 21/2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending death. ☐ Accident 1 Yes 2 No the Investigation 24 hours after deal Funerel Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by the Hospital Medical 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NAple MBBS RES 000 NOVEMBER 12 2012 2401 WBELVEDERE AVE. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MBBS NACHIKET APTE SINAI HOSPITAL 3 OF BALTIMORE BALTIMORE MD 21215 31. Date filed (Month, Day, Year) NOV 1 9 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 0011 М Annabelle Smith November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Joyn, or Location of Death Examiner 4c. County of Death HOSPITAL NES NA nmore Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Month Day, Year) Months Days Hours 220-24-9297 Director 1 M 2 XF 84 MD 28a-f shov 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar mast be notified at the Maryland 10d. Inside City Limits Director Baltimore MD NA XX Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 USA 911 Honaker Court death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. African δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Completed 3 Widowed 4 Divorced Specify: American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Little Joe's 12th Grade NA Salesperson Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ၉ Margaret Carter Staples permit. Page 1 and 2 should by Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5432 Fairlawn Avenue Baltimore, Maryland 21215 Carolyn Lann-Purcell-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Mt. Zion Cemetery 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 11-20-12 Lansdowne, MD 4 Donation 5 Other (Specify). 21. Signature of Funeral Service License Wylie Funeral Home P.A. 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, Maryland 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ⊭nysician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) j Mea Examiner Due to (or as a consequence of): Sequentially list conditions, if any leading to immedia cause. Enter Underlying Due to for as a consequence of Exami burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery Box 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 menths?

1 Yes 2 No

9 Unknown Ectopic pregnancy ò Month be detached the g Unknown P.O. ģ page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed this certificate 1 Yes 2 No Yes 2 N funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 No မှ ER/Outpatient 3 DOA 1 Inpatient 2 🔽 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 8c. Injury at 28d. Describe how injury occurred the Hospitai or Attending To the Hospital within 24 hours effer deeth.

To the Funeral Director: After the function of t 5 Pending ✓ Natural injury work? 1 ☐ Yes 2 ☐ No 2 Accident Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, geam occurred at the time, date and place, and due to the cause(s) and manner as stated
☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0058141 Novem Der 14.2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S. Caton Ave Baltimore, MD 21239 Williams Wendie MD

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death ecedent's Name (First, Middle Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 25 Vincent Rd. Essex Baltimore . Social Security Number **Funeral** 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) 220 22 1185 84 Director 1 - M 2 M F Oct.8,1928 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event: the Mariant Economics. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25 Vincent Avenue 21221 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Hsual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Cafeteria Worker Baltimore County Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph John Paulus Mary Anna Robl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Lea Gardner (Personal Rep) 23 Vincent Avenue Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 N Burial 2 Cremation 3 Removal from State Most Holy Redeemer Cemetery 11/19/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex John Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Lung cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): signed by the attending physician and defected for use as the burial-transit Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Day Month Pregnant at time of death 5 Other (specify) Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown eral pirector: After this certificate has been si filled in by the funeral director, page 2 should i 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed^a death? Yes 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes ρ After this 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury death. ☐ Accident 1 ☐ Yes 2 ☐ No Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number MsRajapaln 11/16/12 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar NSRAJAPAKECMO

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

32. Registrar's Signature

mim

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Baltimore MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 2:18 04 2012 Baby Boy Squire /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Director <u>infant</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Director Examiner must be notified 1 ☐ Yes 2√ No MD Washington Hagerstown 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 5 items 23a 21740 USA 917 Maryland Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 🔀 No Specify: à Specify: black 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 27 is marked other 4- any injury or other traum-Elementary/Secondary (0-12) College (1-4 or 5+) infant infant infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be Chauntae Squire ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johns Hopkins Bayview Med Ctr 4049 Eastern AVenue Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ♥ Other (Specify) in state 21. Signat Funeral Servi Licens Koll LL S 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Patt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death a Wetern premature rupture of Membraneo [15 weeks gestation] Immediate Cause (Final Physician lagy disease or condition resulting in death) /Medical **Examiner** SITIMONNUMBONITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed nding physician and use as the burial-tran of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year ed by the att Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Id be de þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 a autopsy certificate has perform 1 🗌 Yes 2 🗌 No Physician: 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA ၉ 1 Inpatient 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: s after death. Division or Attending 1 Natural 5 Pending investigation (Month, Day Year) Injury 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital 29a. Certifier 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated within 2 To the I the

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 1 9 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Lillian Sipes Nov 15 2012 1:12p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ellicott City Howard 8669 Ridge Rd If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Director 218-01-0636 1 M 2 F 96 Maryland /19/1916 10a. State at 10c. City, Town or Location Director "natural", or items 23a or 28a-f s edical Examiner must be notified Ellicott City MD 1 ¥Yes 2 □ No Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21043 8669 Ridge Rd death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 9 1 Never Married 2 Married Yes Yes Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify. Specify: White Completed 3 K Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Own Home Home maker 6 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည (nee Keirle) Bertha John l. Drexel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 8669 Ridge Rd Ellicott City MD 21043 Daughter <u>Victoria Sipes</u> other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of h Important: If ite any injury or ot once. 1 🕏 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Woodlawn Cemetery 11/20/12 21. Signature of Funeral Service Licen 22. Name and Address of Facility Craig Witzke Funeral Care M00751 Newburg Ave. Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 mor 1 Yes 2 N 9 Unknown signed by the at Id be detached for 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autons Yes 2 No in 24 hours after death.

he Funeral Director: After this certification in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 Hospital မ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death

1 De Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28d Describe how injury occurred 28c. Injury at Certificate: Hospital or Attending 5 Pending injury work 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

within 2

Medical

29a. Certifie (Check

29b. Signature

only one

DHMH 17 Rev 06-2011

Registrar

Fairmount

Medical Examiner: On the basis of examination and/or investigation

leted cause of death

515

32. Registrar's Signature

Certifying Nurse Practitioner: To the best of my k

dress of person who come

an

Shorofsky

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Ave

n, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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h occurred at the time, date and place, and due to the cause(s) and manner as stated.

MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			State Registrar 1. Decedent's Name (First, Middle, Last)	Cei	rtificate of Deatl	2. Date of De	Reg. No.	3/1/0			
F	Physicia		Vera Thompson				aby Day Zolz	3. Time of Death			
	Medic Examin		4a. Facility Name (if not institution, give street and no	umber)	4b. City, Town, or Location		4c. County of Death				
	uneral		Villa Rosa Rehab Cent S. Social Security Number 6. Sex	er 7. Age (In yrs. last birthday)	Mitchellvi If Under 1 Year If Und	der 24 Hrs. 8. Date of Bi	Prince Ge	Porge's			
	irector		578-30-9847 1□M2∑F		Months Days Hour	Nov 6	ay, Year) Cou	h Carolina			
and	show	lor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits			
e Maryl	· 28a-f notifie	Director	MD Prince George	's Hyattsv				1 ☐ Yes 2X No			
with the	23a oi ist be	Funeral [10e.Street and Number 1000 Brightseat Road $\#$	169	10f. Zip Code 20785		10g. Citizen of What Cou USA	intry?			
death	r items iner m		Armed I	orces?	Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Specify Yes or No ican, Puerto Rican, etc.)	14. Race - Ameri Black, White,				
036 's after	ral", o Exami	ed by	1 Never Married 2 Married 1 Yes, G 3 Widowed 4 Divorced Year or	s 2X No ive Dates.	1 ☐ Yes 2🏌 No Spec	cify:	Specify: bla				
15-0 72 hou	"natu ledical	Completed	15. Decedent's Education (Specify only highest grade complete	d) (Give	dent's Usual Occupation kind of work done during m	nost of working	16b. Kind of Business/li	ndustry unk			
21215-0036 within 72 hours after	erthar the M		Elementary/Secondary (0-12) College 12	(1-4 or 5+)	o NOT use retired) etaker						
and be filed	ed oth	To Be	17. Father's Name (First, Middle, Last) Vernon WIlliam Massey			other's Name <i>(First, Middle</i> Sallie Gertru					
aryline hould be	s mark		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Nur Belle Have			Code)			
re, M	em 27 i		Patricia Thompson/d			1					
Baltimore, Maryland permit. Page 1 and 2 should be filed	Department or result and wenter raybene. Importants if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 🛣 Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place)									
Balt permit.	Import any inj once.		21. Signature of General Service Licen RONATI		Name and Address of Fa State Anatomy Baltimore, MI		W. Baltimore	Street			
	A.E.		23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on	t caused the death. Do not ent each line.	er the mode of dying, such	as cardiac or respiratory a		Approximate Interval Between			
	ician/ ledical		Immediate Cause (Final disease or condition resulting in death)	o (or as a consequence of):	encer with	Unknown 1	Primary	Onset and Death			
Exa	aminer	_		o (or do d our long do not on).			124				
pa	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of):							
execut	an and rial-tra	Exa	that initiated events C. ———	o (or as a consequence of):							
760 ate be	physici the bu	edical	d								
certific	anding use as	m/M	zob. was decedent pregnant	utcome of pregnancy e Birth 2 ☐ Fetal death 3 [☐ Ectopic pregnancy		23d. Date of deli	very			
P.O. Box 68760 that the death certificate b	been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med		egnant at time of death 5	Other (specify)		Month Day Year				
P.O	gned by	ρ	Part II. Other significant conditions contributing to	death but not resulting in the u	underlying cause given in P		obacco use contribute to the cause of death?				
ords,	been si should	Completed				1	Yes 2 No 3 Pro	opsy findings available			
Secondary Person	S C	dmo				auto	opsy prior to o ormed? death?	ompletion of cause of			
tal F	ector, p	Be	25. Was case referred to medical examiner? Hospital:			Death (Check only one)	2 3 10 1 1 100				
of Vi	er this c	e: To	1 [Yes 2 2 9 No 1] [27. Manner of Death 28a. Dat	Inpatient 2 ER/Outpatiene of injury 28b. Time of			idence 6 Other (Special how injury occurred	(y)			
ion (eath.	or: Afte	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	onth, Day, Year) injury	M 1 ☐ Yes 2	! □ No					
Division of Vital Records, tal or Attending Physician: The law requires after death.	al Direct ed in by		4 Homicide determined 28e. Place	ce of Injury - At home, farm, str ding, etc. (Specify)	eet, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physician: To the Check Only one 3 Gertifying Nurse Practition	asis of examination and/or inves	tigation, in my opinion, death	h occurred at the time, date	and place, and due to the c	ause(s) and manner stated.			
To th	To th comp		29b. Signature and title of certifier		29c. License numbe	er	29d. Date signed (Month,	Day, Year)			
			20 Name and address of season	tion of doubt and on the	D0083	455	November	815015			
			30. Name and address of person who completed ca	3 800 WHs.	fordVista	Road Mi	tzhellulla	, Md			
إ	Stat Registra	e	NOV 1 9 2012	use of death (trem 23a) (Type, Registrar's Signature	Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #24a-2/ Per PHY G933 11/19/2012 JH
State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death olson Month Physician/ loyd 6.05 AM 2012 94 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death brest ville nursma GROVSE home Porestuille MINCE 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Hours Director 1 X M 2 🗆 F Washington DC 76 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2X No IND 10e. Street and Numb 10g, Citizen of What Country? "natural", or items 23a Funeral 1-5. 7420 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cubay Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or I any lighty or other traumatic event, the Medical Examinance. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify 3 ₩idowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 m transportation Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Tolson Ada Marie Tilghman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lafonda Tolson/daughter 1710 Urby Court Upper Marlboro, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Board 4 Donation 5 Other (Specify) 11-4-12 Anutomy formere MID MD-Similar of Funeral distributes ade, Director State an Anatomy Board 655 W. Baltimore Street Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line bstractive Dulminary diseas Immediate Cause (Final Physician/ Chronic disease or condition resulting in death) Medical Due to (or as a consequence of roscherotic cardyvascular disc Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician sthe burial Physician/Medical 1) Division of Vital Records, P.O. Box 68760 as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death signed by the a 1 L Yes 2 L 9 L Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Weakness 1 Yes 2 No 3 Probably 4 Unknown page 2 should been Kidney Were autopsy findings available prior to completion of cause of chronic. 24a. Was an After this certificate has autopsy performed Yes 2 death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 \mathbf{X} Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred XNatural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune

completely f (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number 11-05-2012 1) 51520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WASHINGTON DC, 20032 southern Dra. SE PISHDAD, MO

DHMH 17 Rev 06-2011

State Registrar BAHRAM

31. Date filed (Month, Day, Year)

<u>NOV 1</u>

1328

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Theodore A. Turner 10 8:00 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Silver Spring Silver Soring
If Under 1 Year If Under 24 Hrs. Montgo mery

9. Birthplace (State or Foreign
Country)
unk MCHS 8. Date of Birth (Month, Day, Year) Mar 5, 1940 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 1 M 2 □ F Hours 72 272-36-8959 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Howard Columbia 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5755 CEdar Lane 21044 IISA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married unk 1 ☐ Yes 2 ☑ No Specify: Specify: black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be unk ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2501 Musgrove Road Silver Spring MD 20904 of Disposition (Name of Date 20c. Education - City or Town, State Manor Care Silver Spring 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify) in state 21. Signature of Euneral School Lice Lice Transcription 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic prostate carcinoma Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 robably 4 Unknown 1 ☐ Yes 2 ☐ No Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 No P

Physician /Medical Examiner law requires that the death certificate be executed

Funeral

Director

28a-f show at notifled

ms 23a or 7 r must be n death with

Examiner

the

7 is marked other traumatic event, the

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, once.

9

"natural",

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filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0036

burial-trar physician the as attending use for signed by the a d be detached f page certificate this funeral Jospitan C.
4 hours after dec.
- neral Director; Andre in by the fu

27. Manner of Death

1 XNatural

2 Accident

3 Suicide 4 Homicide

31. Date filed (Month, Day, Year)

NOV 1 9 2012

Division or Vital Records, P.O. Box 68760,

Physiclan:

Hospital or Attending

within 24 hours at completely

d to medical	26. Place of Death (Check only one)									
0	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 DC	OA Other: 4 Nursing He	ome 5 ☐ Residence 6 ☐ Other (Specify)						
5 ☐ Pending investigatio	(Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred						
6 Could not be determined	28e. Place of injury - At hor building, etc. (Specify)	ne, farm, street, factory	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Certifying Ph	ysician: To the best of my know	ledge, death occurred	at the time, date and place	, and due to the cause(s) and manner as stated.						

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurrence on the basis of examination and/or investigand manner stated.	rred at the time, date and place, and due to ation, in my opinion, death occurred at the t	the cause(s) and manner as stated. me, date and place, and due to the cause(s)		
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)		
CNP	R114730	10-26-2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
Monica Immordino 2501 mus	grove Rd. Silver	- Spring, MD. 20904		

State Registrar

Medical Certification:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) ovember 10 Year 2012 **Physician** James Iransou /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) If Under 24 Hrs. Hours Min. 6. Sex If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 🔀 M 2 🗆 F 71 Sept 17, 1941 Virginia Director 225**-**54**-**3171 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important; If Item 27 is marked other than "natural" —— any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√ Yes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21205 USA 4901 Wright Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify. þ Specify: white 3 ☐ Widowed 4 🕅 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 0 bus driver transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Everett Transou Elva Lorrine Mathews ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4901 Wright Avenue Baltimore, MD 21205 Gail Chandler/friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Forerel So Ronald 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street w Baltimore, MD 21201 enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCUD Physician /Medical Due to (or as a consequence of) **Examiner** naestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Examiner Due to or as a consequence of) that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4 Tegnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 TUnknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 □ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1X Inpatient Other: $_4$ \square Nursing Home $_5$ \square Residence $_6$ \square Other (Specify) 1 ☐ Yes 2 💢 No 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 1 Al Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🗌 Yes 2 🗌 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ORIGINAL

29c. License number

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After the completely filled in by the funer the

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GriffIN James

4940 Eastern Avenue, Baltimore, MD, 21224

November 10, ZUIZ

State Registrar

(check only

29b. Sign

Registrar's Signa

and manner stated.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Linda L. Thomas Joven ber 10:15 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year, **Director** 180-28-6044 1 M 2 XF 75 Feb 10, 1937 Pennsylvania permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extrainer must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 South Way 21146 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 🛣 No If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【 No Specify: Specify: white 3

Widowed 4 □ Divorced Completed Year or Dates Thomas 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 4 media assistant County schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Leroy Liddick Edith Helena Hess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hugh Thomas/son 856 Cottonwood Drive Severna Park, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔲 Burial 2 🗆 Cremation 3 🗔 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Sign ROTTALE State Anatomy Board 655 W. Baltimroe Street Director MD Baltimore. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ Gastronrestinal Bleed disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Acute myscardial Sequentially list conditions, Due to (ut as a consequence oi). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 📈 No Certificate: To 1 [Vinpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 1 X Natural Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 A Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KHOWERCNY-BL November 8, 2012 K107527

Registrar

State

301 Hospital Dr. Glen Burnie MD 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kim Howa

NOV 19

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2012 7:30A Jean Main Valenti Nov. 16 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll 139 Ponytail Lane Taneytown If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 043-14-9150 Days 90 Director 1 M 2 XF 6-10-1922 CT2 should be filed within 72 hours after death with the Maryland Ith and Mental Hygiene.
27 is marked other then "netural", or items 23a or 28e-f show treumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll Taneytown MD 1 Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 139 Ponytail Lane 21787 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Bookkeeper Bookkeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Elizabeth Murphy Clifford C. Main 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 sh Department of Health ar Important: If Item 27 is eny injury or other treu Frank Valenti-son 139 Ponytail Lane, Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Norwalk, CT John Cemetery 11-20-12 4 ☐ Donation 5 ☐ Other (Specify) St. of Funeral Service_License 21. Signatur 22. Name and Address of Facility Fletcher Funeral & Cremation Main St., Westminster, MD 21157 E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir or Attending Physicien: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ettending physiclen a d for use as the buriel-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time = ** 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Vaai signed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signe; pege 2 should be 2 No 3 Probably 4 Hrknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed After this certificate funeral director, peç Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes ည 2 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Hospitai Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 5203 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster MD 21150 15120 CHACKO 295 Stones 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 1:04 PM Physician/ Eddie Dan Williams NOVEMBER to 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/ASINAL OF BALTIMORE Baltimore HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 1 ☑ M 2 ☐ F Director 280-38-1202 Ohio 69 01/26/1943 **'Usual Residence of Decedent** 10d. Inside City Limits shov 10b. County 10c. City, Town or Location 10a, State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If the 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MD N/A1 ¥ Yes 2 □ No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 7121 Park Heights Ave. Unit 21215 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Bus Driver Ohio State Univ. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Johnnie Munnderlyn Add Williams 19a. Informant's Name/Relationship (Type, Print) Costella Williams (Wife) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 11/30/12 Owings Mills, 21. Signature of Funeral Service Licensee ²² Joseph H. Brown, Jr. Funeral Home PA 2140 N. Fulton Ave. Balto., MD con 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner RESPIRATORY FAILURE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ATHEROSCLEROTIC Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Pregnant at time of death 1 Yes 2 No signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24 hours after death.

• Funeral Director: After this certificate has been sis letely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 2 To the only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10, 2012

Registrar

DHMH 17 Rev 06-2011

State

KNOWN AS: DAN EDDIE

HOSPITAL

SINAI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GOSAIN

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NOV 1

31. Date filed (Month, Day, Year) -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death 10:22 Am Physician/ Evelyn Patricia Wilson Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner rs. last birthday) If Under 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Maryland 11/22/1940 213-42-3124 **Director** 1 M 2X F 10d. Inside City Limits 10b. Counfy 10c. City, Town or Location Director notified 1 Yes 2 XNo 28a-f Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ems 23a or r must be r Funeral U.S.A. 21040 49 Littlecreek Lane 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) $0.0130 \land 60e \$ Was Decedent Ever in U.S er than "natural", or iter the Medical Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 2 XNo 1 Yes 2 No Specify If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 9 Homemaker is marked other Be Page 1 and 2 should be filed ment of Health and Mental Hy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Hanson Evelyn May Nelson Leon Wharran 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 5108 Lincoln Highway West, Thomasville, Pa. 17364 Anthony Wilson (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 11/20/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Bayview Crematory Signature of File of Control Licensee 22. Name and Address of Facility nski Funeral Home, P.A. Old Eastern Avenue, Essex, Maryland 21221 1407 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death prediate Cause (Final sease or condition sulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Other (specify) Pregnant at time of death been signed by the s should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 1 Yes 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No ٥ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 1 🗌 Yes 2 🗌 No 28d. Describe how injury occurred 5 Pending iniury 1 Natural Accident Investigation within 24 hours after death

To the Funeral Director; of completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) D0067697 Name and address of person who Square Dr. Balto, MD, 21237 31. Date filed (Month, Day, State Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician/ DERICK WALLACE WHILDINI Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Perry Ceci -MARYLAND HEALTH CARESYSTEM If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) 214-76-0330 **Director** 1 ☑ M 2 ☐ F 1958 Sept 29, Lunstul 27 is marked other than "naturai", or items 23e or 28a-f show traumatic event, the Miclical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Ceci1 CO1ora 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 831 Harrisville Road 21917 USA unk 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 X No Specify: white 3 Divorced Year or Dates. 177-78 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education unk 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. d other than " Elementary/Secondary (0-12) College (1-4 or 5+) Be pe filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 2 Frederick W. Whildin I Bettie Lou Shaw permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VA MD Health Care System 361 Boiler Road Perry Point, MD 21902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state 21. Signature of Funeral Service Licensee Ronal d S Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director timore, MD 23a. P. L. Enter the dialese, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ consistant with Malignary MASS hilar Medical Due to (or as a consequence of): **É**xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physiclan: The lew requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical Exam Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Day 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Chronic obstructive PulmonARy disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Pheumonia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 2-N disorder Seizure 2 🗆 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 KCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier sauro

Registrar
DHMH 17 Rev 06-2011

State

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

VA Maryland Health Care System

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Melecia Santos M.O.

31. Date filed (Month, Day, Year) NOV 1 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Albritton 1913pM 201 Annie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Cheverly Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year, Hours Min. Months Director 241-52-3013 1 □ M 2 🗹 F North Carolina 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10c, City, Town or Location Director 1 Yes 2 No MDPrince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2722 Hawthorne Terr 20785 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Narried Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Private 12th Librarian Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Chapman Hughey St. Clair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2722 Hawthorne Terr. Landover, MD 20785 Hugh Albritton/Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-24-2012 Brentwood, Maryland Lincoln Cemetery: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. earson VOI 7474 Landover Road, Hyattsville, MD 20785 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Enysician/ cardiovasa disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner SP Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 盎 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕅 No မှ 1 Inpatient 2 KER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 0067326 2012

State Registrar 31. Date filed (Month, Day, Year)

NOV 2 0

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 2

		-	For State Registrar	Otate of W	Ce Ce	rtificate of L			Reg. No.2	012	37180	
	Physicia	n/		Decedent's Name (First, Middle, Last)					2. Date of Death Month Day Year November 18, 2012 12:15 A M			
	Medic Examin	_	Audrey Delozie 4a. Facility Name (if not institutio		4b. City, Town, o	r Location of Death		4c. County of Death				
			Manor Care Po	tomac		Potoma				tgomer		
	Funeral Director		5. Social Security Number 579-09-3598	6. Sex 7. Ag	ge (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da September	v Year)	Coun	place (State or Foreign try) y Land	
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, Town or L	ocation		-		1	0d. Inside City Limits	
	//arylar 8a-f s tified	Director	Maryland Mont	gomerv	Bethesda						1 ☐ Yes 2 🏋 No	
	a or 2 be no		10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?	
	th with ms 23 must	Funeral	8235 Bradley	Boulevard	Everial IS 13	20817 Was Decedent of H	lispanic Origin? (Sr	pecify Yes or No-		ed Stat		
90	fter des , or ite aminer	by	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	Armed Forces? arried 1 ☐ Yes 2 🔀	I No	If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		Black, White,		
8	ours a atural' cal Ex	eted	3 X Widowed 4 ☐ Divorce	Year or Dates.	16a, Dece	edent's Usual Occur				of Business In		
215	n 72 h e. ian "na Media	Completed		hest grade completed)	(Give	kind of work done during most of working OO NOT use retired)		king	TOD. KING C	OT DUSTINGSS III	doory	
2	d withi	Be Co	12			emaker	40 Mathada Nas	Own Home				
Maryland 21215-0036	be file ental H ked of	To B	17. Father's Name (First, Middle,						, Maiden Surname)			
ary	12 should be file lith and Mental H 27 is marked o r traumatic eve	ă	George Benjam 19a. Informant's Name/Relation			3	and Number or Ru	Lucinda Boswell Rural Route Number, City or Town, State, Zip Code)				
<u>√</u>	and 2 s fealth im 27 her tra		Sydne Archer	Murphy/ Daug		Bradley	Boulevar					
nore	age 1 ant of H		20a, Method of Disposition 1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other	on 3 Removal from State	20b. Place of Disp cemetery, cre Montgome	ematory or other place cium, Inc	^{ce)} Nov	ember 2012		ion - City or To		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service		Cremator	<u>rium, inc</u> 22. Name and Addre Bethesda-(ess of Facility Ro Thevy Cha	bert A. I	Pumphr.	ey Funday Wiscon	Maryland eral Home/ nsin Avenue	
	00700		23a. Part 1. Enter the disease,	or complications that cause	d the death. Do not er	Bethesda, iter the mode of dyi	Maryland ng, such as cardiac	20814-	3501 rest,	1	Approximate	
44	hysician/	e n	shock, or heart failure. List Immediate Cause (Final disease or condition	t only one cause on each lin	ANCEL	AGE					Interval Between Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as	a consequence of): ILURE a consequence of):	To 7	THRIVE	,				
		ner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying	b. Duw to (or as	a consequence of:	7.0	77(***					
	outed nd ransit	Examiner	Cause (Disease or iinjury that initiated events	a. DE	DEMENTIA Due to (or as a consequence of):							
0	icate be executed physician and s the burial-transit	ledical E	resulting in death) Last	Due to (or as	a consequence on.							
8760	ificate ig phy as the	Medi	IF FEMALE:	0								
89 xc	eath certifica attending p for use as t	Physician/W	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐ Ectopic pregnan☐ Other (specify) _	ю		23d. Date of delive Month		rery Day Year	
P.O. Box	he dea y the a iched f	hysic	1 Yes 2 No 9 Unknown	g ☐ Unknown								
P.0	es that the designed by the a	þ	Part II. Other significant condi	tions contributing to death	but not resulting in the	underlying cause g	iven in Part I.				he cause of death?	
rds	require been si should b	eted						24a. Was			ppsy findings available	
ecc	he law te has l	Completed							opsy ormed? 2 X No.		impletion of cause of	
ia F	sian: T ertifica ctor, p	Be C	25. Was case referred to medica examiner?	-			Place of Death (Che		Z JAL HOT			
f Vii	Physic this ce al dire	은	1 Yes 2 No	Hospital: 1 Inpa 28a. Date of inj	tient 2 ER/Outpati		4 Wursing F	lome 5 Resi			y)	
o uc	nding ath. r: After e funel	icate	1 Natural 5 Pend	/A Annah D		Wor		ZCG. DCSC/IDC	n (Street and Number or Rural Route Number, Town, State)			
Division of Vital Records,	or Atterdater des Director in by the	Certificate:	3 Suicide 6 Coul 4 Homicide dete	zminod 28e. Place of In	ijury - At home, farm, s tc. (Spec <i>ify)</i>	treet, factory, office						
O	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (29a. Certifier 1 Certifyi	ing Physician: To the best on the basis of	of my knowledge, death	n occured at the tim	e, date and place,	and due to the ca	ause(s) and m	nanner as stat	ed.	
	the He	Med	only one) 3 Certifyi	ing Nurse Practioner: To the	e best of my knowledge	e, death occurred at t	he time, date and pl	ace, and due to the	he cause(s) an	nd manner as s	tated.	
0	5 6 00		29b. Signature and title of certif		f mo	29c. Licen:	5745	8,	11/1	igned (Month, $9/12$	say, roar	
·	101/		30. Name and address of perso	on who completed cause of	death (Item 23a) (Type	, Print)				, ,		
	100		Pinky Singh, 31. Date filed (Month, Day, Year,	M.D. 8218 Wi	sconsin Av	enue # 30	5, Bethes	sda, Mar	yland	20814-	3501	
	Sta	te	NOV 2 0 20	19 6 32. Hegist	trar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	iryiariu /		tificate of		ariu iv	ена пу	gierie Reg. No	001	0 07101
			Decedent's Name (First, Middle, L.	ast)		-				2. Date of De	ath	201	3. Time of Death
	Physicia Medic		Delia Iren	e Arredond	0					Month Novem	ber ber		
	Examin		4a. Facility Name (if not institution, gir	e street and number)	4b. City, Town, or Location of Death			4c. County of Death			eath		
	<u>-</u>		Gilchrist Hos 5. Social Security Number 6.			th day d	Colu	mbia IfUnder	24 Wro 1	0 P-+- (P)		Howard	
	Funeral Director			1 □ M 2 K F	(In yrs. last bin		Months Days		Min.	8. Date of Bir (Month, Da		9. 6	Birthplace (State or Foreign Country)
			Usual Residence of Decedent		69	Yrs.				Nov. 1	6, 1	943 M:	ichigan
	yland f sho	tor	10a. State 10b. County		10c. City, Tow	n or Loc	ation						10d. Inside City Limits
	28a-	Sire	MD Howard 10e. Street and Number		Col	umb:							1 ☐ Yes 2 🗓 No
	ith th	rall	6274 Amherst A	lyonuo			10f. Zip Code	0.46				tizen of What	Country?
	ems a	Funeral Director	11. Marital Status	12. Was Decedent Ev	ver in U.S.	13. V		046 Hispanic Orio	in? (Spe	cify Yes or No-		USA 14 Bace : An	nerican Indian,
ထ္	ter de , or it		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐X1	No		/as Decedent of Yes, specify Cut					Black, Wh	nite, etc.
8	urs al tural"	ted	3 ☐ Widowed 4 Divorced	If Yes, Give Year or Dates.		1	X Yes 2 □ N	o Specify:	Mex	ican		Specify: H	ispanic
45	e filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Evandering that he notified at	Completed by	15. Decedent's (Specify only highest of		16a	(Give k	ent's Usual Occu ind of work done O NOT use retired	during most	of workin	ng	16b. K	and of Busines	ss/Industry
77	ed within Hygiene. other thai		Elementary/Secondary (0-12) 12th	College (1-4 or 5-	+)		stomer S	,	.		Lei	gure Wo	orld of MD
פָּ	filed v al Hyg d othe	Be	17. Father's Name (First, Middle, Last)	<u> </u>			T		(First, Middle,			DITO OF ME
<u>ya</u>	uld be file Mental harked o	욘	Jose Arredondo					A	meli	a Rodr	igue	z	
Maryland 21215-0036	should and Me Is mar raumati		19a. Informant's Name/Relationship	Type, Print)	198	o. Mailin	g Address (Stree	t and Numbe	r or Rura	l Route Numbe	er, City or	Town, State,	Zip Code)
	1 and 2 should be filed wit of Health and Mental Hygie item 27 Is marked other other traumatic event, the		Adam J. Hebert/S	Son			Amhers	t Aven					1046
Baltimore,	o - = 5		1 Burial 2XX Cremation 3	Removal from State	cemete	ry, crem	sition (Name of latory or other plants		_)ate		•	or Town, State
Ħ	permit, Page Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Spe- 21. Signature of Funeral Service Lice		west		Name and Addr			/2012		enton,	ome, P.A.
ä	permit. Departi Import any inji		Daniely	nook	M01103		.3 Talbo						
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	nplications that caused	the death. Do	not ente	r the mode of dy	ing, such as	cardiac o	r respiratory ar	rrest,		Approximate Interval Between
	nysician/		Immediate Oause (Final disease or condition	DA			CAM						Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a									
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	off:							
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687			IF FEMALE:	00- 14	7.00.0.0571								
Box (ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of Live Birth 2 4 Pregnant at	Fetal deat		Ectopic pregnar Other (specify)	псу				23d. Date of o	delivery Day Year
œ.	Physician: The law requires that the death certifiths certificate has been signed by the attending rail director, page 2 should be detached for use a	Physician/N	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	time of death	J [_	Other (specify)						-,
P.0.	that the		Part II. Other significant conditions	contributing to death bu	t not resulting	in the ur	nderlying cause o	jiven in Part I		23e. Did t	tobacco u	use contribute	to the cause of death?
ds,	quires en sig ould b	Completed by								1 🗆	Yes 2	⊠No 3□	Probably 4 🗌 Unknown
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<u>\$</u>	Phys r this eral di	e:	27. Manner of Death	28a. Date of injury	nt 2 ER/O	utpatien	1 3 □ DOA □	4 ∐ Nu		me 5 Resi		Other (Sp.	ecity) trospice
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ă	oital o urs af ral Di			210					- 1				
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check 2 L Medical Example 1)	ysician: To the best of n niner: On the basis of ex	amination and/o	or investi	gation, in my opir	ion, death oc	curred at	the time, date a	and place	, and due to th	e cause(s) and manner stated.
	Fo the within Fo the	Σ	only one) 3 ☐ Certifying Nu 29b. Signature and title of certifier	rse Practitioner: To the	Dest of my kno	wleage,	29c. Licen				204 Da	to signed (Mos	nth Day Voorl
	0		M Asta	mu Re	Cen.	wo	Do	152a	5		No	sembo	208
	3 m		30. Name and address of person who	completed cause of de	ath (Item 23a)	Type, P	rint)		7	0 00		113	206
	V		M. H. Keley	UBM		011	V. Chn	ries J	<i>J</i> .	BALTU	. VV	10 21	207
	Stat Registra	.0	31. Date filed (Month, Day, Year) NOV 2 0 2012	32. Registrar	's Signature	ne	,						
			TOTA V LVIL	- Marie - J	- July 14								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EDWIN A. ANDREWS, JR. 0411 November 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritian Hospital Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 9/22/1924 Davs Hours Country) Director 219-22-5691 1X M 2 | F 88 Yrs MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director r than "natural", or items 23a or 28a-f si the Medical Examiner must be notified 1 Yes 2 X No MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3208 SPERL COURT 21234 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent
Armed Forces?

1X Yes 2 No
Ves. Give WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates. Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health end Mentel Hygiene. tant: If Item 27 is marked other tha lury or other traumatic event, the new POLICE OFFICER 12TH GRADE CITY POLICE DEPT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDWIN A. ANDREWS, SR. MARGARET EY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If Item 27 any injury or other tr once, BEVERLY J. HUEBEL/DAUGHTER 2908 SHELLEY COURT ABINGDON MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLY ROSARY CEMETERY 11/23/2012 DUNDALK. MD 22. Name and Address of Facility JOHNSON-FOSBRINK FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MO1139 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or compli-ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one to use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ septic shock Medical resulting in death) Due to or as a consequence of): Examiner lactic acidosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine ate has been signed by the attending physician end page 2 should be detached for use es the burlal-transit aspiration certificete be executed prey monio Due to or as a consequence of resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed' After this certificate Yes 2 🖭 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3
Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital c within 24 hours a' To the Funeral D completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES OCC November 19, 2012 M.P. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tiffani Pittman Loch Raven Blud, Baltimore MD 5601

State

Registrar

31. Date filed (Month, Day, Year)

NOV 20

REW S

4

12-08424

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ames Adams	State of Maryland / Departme 1- For State Certifica Registrar	nt of Health and Mental Health The of Death	ygiene Reg.	No. 2012	37183
Physician/	Decedent's Name (First, Middle,Last)		Date of Death Month November 6		Time of Death
Medical Examine	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		, 2012 4c. County of Death	1515 1115
).	5100 Raintree Way Apartment J	Baltimore		To board, or board	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24Hrs Months Days Hours Min	8. Date of Birth(Foreign	olace (State or etry) MD
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	r Location			Od. Inside City Limits
	MD Ba	ltimore			1 X Yes 2 No
the Marylanc a or 28a-f sh tiffied at one Director	10e. Street and Number 5100 Raintree Way Apt J	10f. Zip Code 21206	10g.	Citizen of What Count USA	y?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto		14. Race - America White, etc. BI	an Indian, Black, ack
ural", ural", by F	Widowed 4 Divorced in res, give reer or Dates:	1 Yes 2 No specify: ecedent's Usual Occupation (Give kind of	work done	Specify: 6b. Kind of Business/In-	
2 hour "natu	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT use reti		ob. Name of Besiness.	
5-0036 ed within 72 hour lygene. other than "natu the Medical Exan Completed	12	·	unk		unk
21215-0036 Juld be filed within 72 hours after Mental Hygiene. marked other than "natural", ic event, the Medical Examine. To Be Completed by	James Adams Sr		(First, Middle, Ma Adams	iden Surname)	
MD 21 ad 2 should alth and Me m 27 is ma aumatic cv	19a. Informant's Name/Relationship (Type, Print) Daughter 19b	Mailing Address (Street and Number or 02 Himalia Circle			
re, MI 1 and 2 s 1 Health a 1 fitem 27		Disposition (Name of cemetery, ry or other place)		20c. Location - City or T	own, State
Baltimore, oemit. Pages I ar Department of Hee Important: If itel injury or other tr	4 Donation 5 Other Specify:			Glen Bur	
Balti permit. Departr Import	21. Signature of Funeral Service Licensee	22. Name and Address of Facility S: ThomasAllenPA			
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not			_	Approximate Interval
Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascul	ar Disease			Between Onset and Death
	or condition resulting in death) Due to (or as a consequence of):				
be executed be executed sician and surial - transit	Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Cauce (Disease or injury that initiated				
ansit	events resulting in death) Last Due to (or as a consequence of): d.				
od, e be executed ysician and burial - transit	UNPENDED AMENDED				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Functal Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burnel cartification: To Be Completed by Physician/Med		Fetal death 3 Ectopic pregn Other (Specify)	ancy	23d. Date of delivery Month Da	ay Year
P.O. Is that the greed by the detached by the by Physical Control of the by Phys		in the underlying cause given in Part I.		acco use contribute to the	
Records, The law requires ficate has been sig			24a. Was an		opsy findings available ompletion of cause of
ecol he law tre has l			autopsy perform 1 ✓ Yes 2	ed? death?	
cian: T certifica certifica ector, pa	25. Was case referred to medical	26.Place of Death (Check	only one)		
F Vit	1 ✓ Yes 2 No Inpatient 2 ER/Ou	tpatient 3 DOA Other Nursi		esidence 6 🗸 Other:	Scene
Division of Vital Records, P.O. sal or Attending Physician: The law requires that the safer death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by P.		ime of Injury 28c. Injury at Work?	26d. Describe no	w injury occurred	
Division o spital or Attending hours after death. neral Director: After filled in by the fune	3 Suicide 6 Could not be determined (Specify)	rm, street, factory, office building, etc.	28f. Location (Str or Town, Sta	reet and Number or Rur tte)	al Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b					
H 3 H 8	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mon November 7, 201	
V	30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner	900 W. Baltimore Street, Baltin	more, MD 212	23	
Stat	31. Date filed (Month, Day, Year) 32. Registrar's Signature		OCME		
Registra		Kel			
DHMH 17 Rev 1/2001	° COR	IGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Anders, Jr. C. Marshall 2012 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Brightview Mays Chapel Ridge Timonium If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 215-14-9901 **Director** 1 🛛 M 2 🗆 F 90 Maryland 20 1921 Nov.Page 1 and 2 should be filed within 72 hours after death with the May/and ment of Heath and Mental Hygiene.

Sant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Timonium 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21093 12261 Roundwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married à Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Entertainment & College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Musician & Teacher Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Woolford Margaret Marshall C. Anders, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Manchester, MD. 21102 4207 Schalk Rd. #1 Viki Anders/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 X Cremation 3 Removal from State 11-19-12 Towson, MD. 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. 21. Signature of Funeral Service I censee and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a ⁴Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to for as a consuguence of attending physician and for use as the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 2 No signed by the at 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate Yes 2 No 1 Yes 2 To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? MANITE Other: 4 Nursing Home 5 Residence 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) funeral Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 🗆 Yes 2 🗆 No 2 Accident Investigation filled in by the **Director:** 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after e Funeral Direc determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hor To the Fune completely fi (Check only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2109 who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Barbara Clarke Bilsborough 2012 November 2:33p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carrol1 Fairhaven Sykesville If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** 220-22-0225 96 Director 1 □ M 2 □**X** July 26 1916 RI Usual Residence of Decede 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State with the Maryland notified at Funeral Director MD Carrol1 Sykesville 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rms 23a or 7200 Third Avenue 21784 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decese:
Armed Forces?
1 Yes 2 No "natural", or ite Black, White, etc. 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced þ Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant; If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examiury or other traumatic event, the Medical Examiung or other traumatic events or other Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏋 No Specify: Specify:white Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Government Elementary/Secondary (0-12) College (1-4 or 5+) missile computer programmer Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Roy Kennedy Bilsborough Eva Drinkwater May 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health Important: If item 27 any injury or other tronce. Ann C<u>. Jeffress (niece)</u> 2060 E. St. George, Utah 84790 163 So 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) X Burial 2 Cremation 3 X Removal from State 11-30-12 North Kingstown, RI 4 ☐ Donation 5 ☐ Other (Specify) Quidnessett Memorial 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Pargrojaight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 and Due to (or as a consequence of): attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death signed by the at I be detached for a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has be director, page 2 s autopsy performe 1 Yes 2 N 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 🔲 Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural iniurv 5 Pending 2 🗌 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined n 24 hous the Funeral Dire-to filled in Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho **To the Fune** completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Mon:

Rd E Ldersburg MD 21784

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 . Degedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4130 ackson Boone 2012 Medical 4a. Facility Name (if not institution, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NIA Nursing Home 117more 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 215-40-4049 1942 Director 1 🗆 M 2 💢 F 0 MDms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21217 12. Was Decedent Ever in U.S Armed Forces?, 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be flied within 72 h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) eacher 1asters Baltimor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trans 20b. Place of Disposition (Name of 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State Randallstown ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mylan 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ onge disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Box 68760 attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown •24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate 2 No Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director; Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Mang 28c. Injury at r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending work 2 \square No 1 Yes Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiners on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MO November 16 2012 leted cause of death (Item 23a) (Type, Print) EUTAW ST JUITE 301 BALTIMORE MD 2129

Registrar

DHMH 17 Rev 06-2011

State

32. Registra 's Signature

Christopher Briggs 12-08653 **UNK UNK** 1- For State Registrar Physician/ **Medical Examiner**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2118 hrs Christopher Briggs November 14, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD Months Min. Days Hours Director 212-41-7799 **Ж**М 2 F 18 Yrs 23 199 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1x Yes 2 No Baltimore, MD 21215-UU30 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic evect, the Medical Examiner must be optified at occ N/A Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 1696 Montpelier Street Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes specia lack 3 Widowed If Yes, Give Year 4 Divorced 1 Yes 2X No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed 10th grade Unemployed 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Mitchell Briggs, Jr. Frilisa Stevenson Be 19a. Informant's Name/Relationship (Type, Print) Frilisa Stevenson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1606 Montpelier Street Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 11/23/12 Þundalk,Maryland 4 Donation 5 Other Specify Bayview Crematory 22. Name and Address of Facility

Chatman-Harris Funeral Home
4210 Belair Rd Baltimore, Maryland 2120

Baltimore Baltimore Baltimore Signature of Funeral Service Lic 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and Modica a. Gunshot Wound of Head Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d and To the Hospital or Attending Physician: The law requires that the death certificate be executiviting 2 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and Completely Illied in by the funeral director, page 2 should be detached for use as the burial - rracompletely Illied in by the funeral director, page 2 should be detached for use as the burial - rracompletely Illied in by the funeral director, page 2 should be detached for use as the burial - rracompletely Illied in by the funeral director, page 2 should be detached for use as the burial - rracompletely Illied in by the funeral director, page 2 should be detached for use as the burial - rracompletely Illied in by the funeral director. Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA Other Nursing Home 5 Residence 6 Other: ٩ 1 🗸 Yes 28a. Date of Injury Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: Nov 14, 2012 1 Natural Subject shot 2043 hrs 5 Pending 1 Yes 2 V No 2 Accident Investigation 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be or Town, State) 28th Street & Fenwick Avenue, Baltimore, Md. (Specify) Alley 4 V Homicide 29a. Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E November 15, 2012 30 Name and address of person who completed cause of death (Item 23a) 4 Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 0 2012 Registrar

DHMH 17 Rev 1/2001 OCMF 2006

OUME

Donnell Bishop 12-08597

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NK UNK	F	State of Maryland / Department of Horostate - For State Certificate of December 1	eath	Reg. I		3718
Physician ledical Examin	1/	1. Decedent's Name (First, Middle,Last) Donnell Bishop		te of Death nth Da vember 12		3. Time of Death 1624 hrs
TEGICAI EXAMINA			City, Town, or Location of Death	verriber 12	4c. County of Death	
		Johns Hopkins Hospital B.	altimore		N/A	
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If 212-08-9571 1 2 F 28 Yrs.	MM/DD/YYYY) 9. Birth Foreign Cour			
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				Od. Inside City Limits
	. 1	Maryland N/A Baltimore	}			1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	<u>ا دو</u>		of. Zip Code	10g.	Citizen of What Count	y?
th the N		410 FICCINAII FIACC	21202			- India Diade
items	# I	Never Married 2 Married Armed Forces? If Yes, s	ecedent of Hispanic Origin? (Specify Y specify Cuban, Mexican, Puerto Rican,		14. Race - America White, etc.	ari iridian, biack,
ffer de) 기	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:	s 2x No specify:		Specify: Blac	
ours a		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's L	Jsual Occupation (Give kind of work do of working life. DO NOT use retired)	one 16	b. Kind of Business/In	dustry
36 in 72 h than "r	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Labore:	-	Tr.	emp Agenc	·y
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	통 -	17. Father's Name (First, Middle, Last)	18.Mother's Name (First,	Middle, Mai	den Surname)	
be file	B B	Daniel Bishop,Jr.	Veronica H			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	-1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad Veronica Bishop 53 Beni	dress (Street and Number or Rural R n Way Nottingha	am, MD	21236	Zip Code)
e, M l and 2 Health item 2	ı	20a. Method of Disposition 20b. Place of Disposition	nlace)		Oc. Location - City or T	
Pages tent of unt: If		1 Burial 2 Cremation 3 Removal from State crematory or other payview Cr		3/125	undalk,Ma	aryland
Baltimore, vernit. Pages 1 ar Department of Hei Important: If ite	Ī	21. Signature of Funeral Service Licensee 22. Name	e and Address of FacilityChatma O Belair Road	an-Ha	rris Fune imore,MD	eral Home
Physician	4	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m	0 2020			Approximate Interval
/Medical.		failure. List only one cause on each line. Immediate Cause (Final disease a. Stab Wounds (2) of Chest				Between Onset and Death
xaminer	1	or condition resulting in death) Due to (or as a consequence of):				
	<u>=</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	amine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death 1 ast				
and and transit	Exa	events resulting in death) Last Due to (or as a consequence or): d.				
te be executed sysician and burial - transit	edical	UNPENDED AMENDED				
876(ifficate ng phy		IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal c	death 3 Ectopic pregnancy		23d. Date of delivery Month D	ay Year
Box 6876(e death certificate the attending phy ed for use as the b	Physician/M	past 12 months? 4 Pregnant at time of death 5 Other	(Specify)		ŀ	
C. BOX tripe death by the atto ached for	됩	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did toba	acco use contribute to t	ne cause of death?
P.C	۾ اھ			1 Yes	2 No 3 Prob	ably 4 Unknown
ords, F	Completed			24a. Was an autopsy	prior to co	opsy findings available empletion of cause of
Recol The law cate has	E		1	perform ✓ Yes 2		2 No
Vital Recysician: The his certificate director, page	8	25. Was case referred to medical examiner? 1 ✓ Vas 2 ✓ No. Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	26.Place of Death (Check only o		esidence 6 Other:	
of Ving Physical distribution of Vineral distribution	의	1 Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury	ry 28c. Injury at Work? 28d.	Describe ho	w injury occurred	
On C tending sath. or: Af	딅	1 Natural 5 Pending Nov 12, 2012 and 1600 hrs	1 Yes 2 ✓ No Subj	ject assau	ulted	
Division of Vital Records, spital or Attending Physician: The law requir hours after death. Ineral Director: After this certificate has been is y filled in by the funeral director, page 2 should by	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, f	,	or Town, Sta	reet and Number or Rur te) d Ave, Baltimore, MI	
10 m		4 Homicide determined (Specify) Local Street 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation	d at the time, date and place, and due t	o the cause(s) and manner as state	d.
To the Ho within 24 b	Medical	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	
		Carol Hallan	O.C.M.E.	1	November 13, 20	
2		30. Name and address of person who completed cause of death (Item 23a)	Minney Chronic Dell's and ASD	21222		
	ato		Itimore Street, Baltimore, MD	21223		· · · · · · · · · · · · · · · · · · ·
Regist		NOV 2 0 2012 James B. Sand				
DHMH 17 Rev 1/20	01	ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Debra Ann Beaner November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign **Funeral** Director 579-74-4305 Usual Residence of D 1 M 2 🖫 F March 26, 1958 54 North Carolina 28a-f show 10a, State 10b. County 10c. City, Town or Location an "netural", or Items 23a or 28a-f sho Wedical Examiner must be notified at 10d. Inside City Limits death with the Maryland **Funeral Director** Prince George's Suitland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3124 Irma Court 20746 US 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates. ò 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. **Black** 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Pege 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Israel Hines Dorothy L. Suggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DaVida L. Beaner/Daughter 3124 Irma Court, Suitland, MD 20746 other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pege 1
Department of
Important: If if
any Injury or o Creation Center of MD 4 ☐ Donation 5 ☐ Other (Specify) November 26,2012 Hanover, MD 21. Signatur ... Ineral Service Licens 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Avenue, Suitland, MD 20746 23a. Part 1. Enter the diséase, or complications man cause shock, or heart failure. List only one cause on each line. e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Cardiomyopathy Medical Due to (or as a consequence of): *Examiner Multiple Sclerosis Sequentially list conditions, if any, leading to immediate cause. Exter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Bone Infection or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Respiratory Arrest Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔯 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 2 🖵 No 1 😾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 8c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 03224 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nooshin Farr, 1500 Forest Glen Road, Silver Spring, MD

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TIEM#7,8,18perFH,G933,1172872012,WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nicolina Mary Bonacci November 2012 ам 16 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Woodholme Assisted Living Pikesville 8. Date of Birth Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral (Month, Bay, Year) 08/28/1934 Days Hours 161 26 0582 Director 1 □ M 2 🗓 F Pennsylvania 88 78 Yrs. Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director 1 X Yes 2 No N/A Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Numbe Funeral U.S.A. 21225 3914 Inner Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Administrative 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Mildred Otterino Francis Cerra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1804 Wye Cliff Court Pasadena, Maryland 21122 Maria McLamb / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/20/2012 Carbondale, Penna. Our Lady of Sorrows 22. Name and Address of Facility Gonce Funeral Service, P.A.
4001 Ritchie Highway Baltimore, Maryland 21225 21. Signature of Fineral Service Licens 23a. Part 1. Enter the disease, or complications that vaused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Projet and Death Immediate Cause (Final disease or condition mean Physician/ Par Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires thet the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physicien for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Day Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 146 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy performed 1 Yes 2 D M director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence ၉ 1 Inpatient 2 ER/Outpatient 3 DOA hin 24 hours after death.

the Funerel Director: After this or appletely filled in by the funeral directors. 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2.

To the F only one) 29b. Signature and title of certified 00 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32: Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bennett 9.50 AM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balti Franklin Square HOS dale mose 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days 9. Birthplace (State or Foreign Country) **Pennsylvania Funeral** Months Hours 87 Director 219-16-9727 1 🛛 M 2 🗆 F 1925 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Dundalk Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 8136 Cornwall Road USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No Specify: White Specify: 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Postal Service 12 years Vehicle Maintanence $\mathcal{B}_{\mathfrak{S}}$ Maryland 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Glenna Buckman Robert Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5661 Blitheair Garth, Columbia, Maryland Robert Bennett Grandson timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State cemetery, crematory or other place) Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lidensee Connective Funeral Home of Dundalk, p.A. 7110 Sollers Point Road, Dundalk, Md. Bai 21222 mo1176 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effect, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1e50515 Atherosc disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to lor as a consequence of cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 2 ☐ No After this certificate 1 ☐ Yes 2 🔄 director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fo 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check one) nd title of certifier 29b. Signature 19. 2012 DO0 60560 M' D. 8 upleted cause of death (Item 23a) (Type, Print) Kheterpo 9000 Franklin Squar: Drive Baltimore MD 31. Date filed (Month, Paly, Year) 32. Registrar's Signature State NOV 2 0 2012 Back Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death NOV. 18. Physician/ 2012 JOHN CALVERT BOND Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD HAVRE DE GRACE ROCKSPRING VILLAGE 6. Sex. 1 M 2 D F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours 85 217-20-4097 11/22/1926 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must ha matter at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Funeral Director FOREST HILL HARFORD MD 1 Yes 2 X No 10g. Citizen of What Country? 105 Zip Code 1 COLGATE DRIVE USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White of E þ 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 3 🗌 Widowed 4 🗌 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) OVERHEAD TROUBLE DISPATCHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NAOMI BELL မ WINFIELD BOND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Towns, State Zie 60de) DOROTHY BOND-WIFE 20b. Place of Disposition (Name of 20a. Method of Disposition Date GARDENS OF FAITH 1X Burial 2 Cremation 3 Removal from State 11/21/12 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SCHIMI NEK FUNERAL HOME Signature of Funeral Salvice Licenses Mck 610 W. MACPHAIL ROAD BEL AIR, MD 21014 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician whenson disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should ATRAL f. hillotia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

within 24 hours after death. To the Funeral Director: A completed

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Dala

3

615 Ld. MacPha ~ m ~ 32. Registrar's Sgnature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D32275

Belair Bo

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ \mathbb{P}^{M} STARLA REA BLEDSOE November 2012 7:28 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Columbia Howard 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours Min. (Month, Day, Year) Country) 214-60-3691 Director 1 - M 2 XX Yrs 61 12, 1951 PA Apr. Usual Residence of Decedent or than "neturel", or iteme 23e or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9511 Haddaway Place 20723 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death . 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2XXNo Black, White, etc. δ 1 Never Married 2XXMarried Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2XXX No Specify: Yes, Give 3 Widowed 4 Divorced White Completed Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiana. Elementary/Secondary (0-12) College (1-4 or 5+) Grade 12 Cashier Grocery Store Be permit. Paga 1 and 2 should ba filed Department of Health and Mental Hy Important: If Item 27 is merked oth any Injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ James E. Te'Ketch Dorothy Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wain Earl Bledsoe 9511 Haddaway Place Laurel, Maryland 20723 spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 24 Cremation 3 Removal from State Arundel Crematory 11/20/2012 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. GK / M00770 313 Talbott Avenue 20707 Laurel, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease, o shock, or heart failure. Lis Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ -UNG CANC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours aftar death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completaly filled in by the funeral director, paga 2 should be deteched for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 No Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 2012 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TONSON 5701 MARKE 32. Registrar's Sign State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Zelda Marian Brown 3:24 pm 2012 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Springhouse of Westwood Bethesda Montgomery 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 577-18-6821 93 1 M 2 K F 08/07/1919 Washinaton. DC 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be natified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Hallandale Beach 1 Yes 2 No Florida Broward 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 33009 1950 South Ocean Drive, #15G u.s.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Office Worker/Model Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Israel Rodbord Rosa Parson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Eisen - Daughter 10401 Grosvenor Place, #1613, N. Bethesda, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If Ite
any Injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King David Mem Grdns [11/18/2012 | Falls Church, Virginia 21. Signature of Funer Service Livensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MOOZD 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused shock, or heart future. List only one cause on each line ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 6 Months Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hyperlipidemia 24a. Was an performed. To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisied Other: 4 Nursing Home 5 Residence 6 Other (Specify) LIVING 1 ☐ Yes 2 🗓 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation
6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D74668 November 16, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IDV Tania Alchalabi, M.D., 15245 Shady Grove Road, #130, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) State NOV 20 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1JAM Donophan Emarish Blakeney low 2012 Medical 4a. Facility Name (if not institution, give street and number) VA CLR C LOCH RAVEN 4c. County of Death Examiner VA CLRC timor If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 12/05/1946 Days Hours Min. South Carolina 1 M 2 □ F Director 65 251-76-8449 Yrs. Usual Residence of Decede 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location filed within 72 hours efter deeth with the Meryland ms 23e or 28e-f sho 1X Yes 2 ☐ No Randallstown MD Baltimore ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 3673 Water Wheel Square 21133 **USA** "netural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1 X Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 X Married δ altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates. AYMY Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry el Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Construction Worker Construction 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nt of Heelth end Mentel H I: If item 27 is merked ot or other trsumetic even Pege 1 and 2 should be nent of Heelth end Mentr Ethel Adams Lanston Blakeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Blakeney / Wife 6508 Knollbrook Drive, Hyattsvile, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State permit. Pege Department of Importent: If sny injury or once. ò 4 ☐ Donation 5 ☐ Other (Specify) 11/17/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Borota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Indicate Cause (Final disease or condition. Approximate Interval Between Onset and Death Cance Lur Physician/ disease or condition Medical resulting in death) **E**xaminer Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physicien: The lew requires that the death certificate be executed ed by the attending physicien and deteched for use es the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? this certificete has been signed rel director, pege 2 should be de Be Completed by Disease Coronar 1 Yes 2 No 3 XProbably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was ... autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 反 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural 5 Pending 1 ☐ Yes 2 ☐ No Director: A Investigation 6 Could not be 2 Accident 3 🔲 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours off To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner To the bast of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier Gertifying Nurse Practitioner To the best of my knowledge, distill a nourised at this time, date and place, and due to the causala and manner as stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number မ 2012 056508

State Registrar

ENA

Bellimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BLVD

32. Registrar Signature

LOCH RAVEN

31. Date filed (Month, Day, Year)
NOV 2 0 2012

XIANGRONG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Baumgardner 7:30 November AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Gilchrist Hospice Columbia 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 300-32-9656 1 ▼ M 2 □ F 73 Nov. 8, 1939 Ohio ıral", or items 23a or 28a-f shov Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Oil City 1 Yes 2 X No PA 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 520 Ahrensville Road 16301 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ٥ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Project Manager permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Baumgardner Mary Harrah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 903 W. Vine St., Mt. Vernon, OH 43050 Judith Baumgardner (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Degrial & Cremation 3 Removal from State Metropolitan Crematory 11/16/2012 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Linens 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, V Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ UNG ANCER Medical resulting in death) Due to (or as a consequence of): Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of): ending physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last the attending physician thed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a compistely filled in by the funeral director, page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) P 1 🗌 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certified 29c. License number SYED Q. ABBOS, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD UMBIA. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER Day 15 1650 Donald Wilbur 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Cheverly Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year, Hours 229-48-6688 **Director** Feb. 4, 1939 73 Virginia Usual Residence of Decedent 28a-f show 10c. City. Town or Location 10d. Inside City Limits with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 □ No Prince George's Marvland Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7818 Lakecrest Drive 20770 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black White etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Melart Jewelers Visual Merchandiser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o Wilbur Budd Bowen Tanzie Lee Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7818 Lakecrest Dr., Greenbelt, MD 20770 Betty H. Bowen (Wife) mportant: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Rappahannockorbaptist 1 X Burial 2 Cremation 3 Removal from State 11/19/2012 Donation 5 Other (Specify) Warsaw, VA Church Cemetery 21. Signature of Funeral Service Licensee Reference and Address of Facility Metropolitan Funeral Service 5517 Vine St., ALexandria, VA 22310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum_{\text{Nursing Home}}\) Nursing Home \(5 \sum_{\text{Residence}}\) Residence \(6 \sum_{\text{O}}\) Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 \(\Boxed{\omega}\) Yes 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F 29b. Signature and title of ce 70102 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 MD HOSPITAL

State Registrar State of Maryland / Department of Health and Mental Hygien 🗲 🖰

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Baynes Year 1508PM **Physician** Elizabeth 4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death Baltmore C 4b. City, Town, or Location of Death Examiner Future Care old Baltimore, MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 09/17/ Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1923 1 □ M 2X F Months 89 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State ir than "natural", or Items 23a or 28a-f ehow The Medical Examinar must be notified at 1 X Yes 2 ☐ No MD Baltimore **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4700 Harford Road 21214 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaker 12 other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 Is marked o Patrick Cullen Edith O'Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Luedtke Niece 847 South Kenwood Road Baltimore MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State = 5 Atlantic Crem 11/16/12 Important: It any injury o Glen Burnie MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of Funeral Service License once. ThomasAllenPA 7090 Ridge Rd Hanover MD 11on Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pulmonary **Physician** nronk resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a solls aquience of): Examiner law requires that the death certificate be executed burial-trans Due to (or as a consequence of) P.O. Box 68760, Physiclan/Medical attending physic IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Š signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 4 DUnknown brillation 1 □ Yes 2 □ No 3 Probably page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed2 certificate ! 2∏ No 1 Yes 2 No 1 Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2♥No ۵ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manper of Death 28b. Time of Certification: To the Hospital or Attending 1 Natural Injury 5 Pending 1 TYes 2 🗌 No within 24 hours after death.

To the Funeral Lirector: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number R1209 arrange make of godff Man TMI (Type Waltham Woods Road, Parkville, MD APPleby 8813 lonua 31. Date filed (Month, Day, Year) NOV 2 0 201 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month November 2012 12:45P M R. Boyd Peggy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 8509 Woodfall Road Nottingham If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (în yrs. last birthday) 8. Date of Birth **Funeral** Days Month, Day, Year July 31, 1 Mary Land Months Director 215-86-3849 1969 1 □ M 2 🗓 F 43 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🏹 No Maryland Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 U.S.A. Deviation 9002 Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Payroll Tax Specialist Finance Ith and Mental Hygie 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic ewe Lycett R. Brogley Peggy Joseph F. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 702 Royal Mile Drive Abingdon, Md. 21009 Cathy Hruz / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park: 11/20/12 Glen Burnie, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ -240 metastatic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events Examine Due to (or as a consequence of): • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) PARK 2 1 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 133409 11/16/12 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATT, LATELLE MO Rd Sharton 1275) Fally 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Months Days Hours 219-26-8835 1 M M 2 □ F Director 75 July 8, 1937 MD or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Rosedale Baltimore Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 5032 Finsbury Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 M Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1960–64 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Government Systems Analyst 12th grade other traumatic event. Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy important: If item 27 is marked oth any injury or other them. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth McGrath ပ Ralph L. Banks, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5032 Finsbury Road, Rosedale, Maryland 21237 Mitsuko Banks - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Hilltop Service Corp. Towson, Maryland 11-20-2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityLeonard J. Ruck, Inc. 5305 Harford Road, Baltimore, Maryland 21214 Signature of Funeral Service Licens Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 ☐ No 1 Yes 2 G g 🗌 Unknown detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of hast autopsy death? certificate 2 🗌 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) 2 🗌 No |2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Mannet of Deatl 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 5 Pending death. 2 🗌 No ☐ Accident Investigation filled in by the after death Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIAM 31. Date filed (Month, Day, Registrar's Signature

ORIGINAL

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11.10 8 DAIDA Year Physician/ Month ERWIN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 072-18-5171 1 X M 2 ∏ F 87 06/22/1925 GERMANY Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. Count 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 725 MT WILSON LANE, #400 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) ACCOUNTANT REAL ESTATE DEVELOPMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental t of Health and Mental pe traumatic AARON BAIDA ROSA SPATZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a 725 MT WILSON LANE, #400, PIKESVILLE, MD 21208 LILLIAN BAIDA / WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I ARLINGTON CEMETERY CHIZUK AMUNO CONG. 1 X Burial 2 Cremation 3 Removal from State any injury 4 ☐ Donation 5 ☐ Other (Specify) 11/19/2012 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure) List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death NTEROCOCCUS ETEREMIA Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate Examine Due to or as a consumuence of cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 _ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death 5 Other (specify) Month been signed by the a should be detached Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by HUPERTENSION Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has la funeral director, page 2 autopsy performed 2 No 1 Tes Yes 2. N Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury death. 2 Accident 1 ☐ Yes 2 ☐ No eral Director: A filled in by the fi Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 128595 112 MM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TACN FEM I NV HAVI, MIN 1.0 DAY 1525 OWINGS MILL MD 21117 MINERY MI AKHANI 32. Registrar's Si State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

erry B. Coles		State of Maryland / D	Department of Health and Mo Certificate of Death	ental Hygiene	0010 0700
		Registrar 1. Decedent's Name (First, Middle,Last)	Certificate of Death	Reg	g. No. 3. Time of Death
Physicia Nedical Exami		Taican B Cales			Day Year 0040 has
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Locat		4c. County of Death
		201 Gibbons Avenue	Brooklyn		Anne Arundel
Funeral		5. Social Security Number 6. Sex 7. Age (In	1 1	Jnder 24Hrs. 8, Date of Birth	(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
Director		214-72-1110 1XM 2/F	56 Yrs. Working Days	ours Mill. 8/13/19	56 VA
y		Usual Residence of Decedent 10a. State 10b. County 10c	:. City, Town or Location		10d, Inside City Limits
ow any		Tob. County	D II.		1 Yes 2 No
Maryland 28a-f show 1 at oncc.	ţċ	10e. Street and Number	Daltmore 10f. Zip Code		g. Citizen of What Country?
ith the Maryland 23a or 28a-f sho	Director	201 11111111111111111111111111111111111			1150
vith th s 23a e noti		11. Marital Status 12. Was Decedent Eve	r in U.S. 13. Was Decedent of Hispanic		14. Race - American Indian, Black,
death w or items must be	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X	If Yes, specify Cuban, Mex		White, etc.
ifter d	by Fi	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No spe	cify:	Specify: Black
ours a		15. Decedent's Education (Specify only highest grade comple	ted) 16a. Decedent's Usual Occupation (G during most of working life. DO N		16b. Kind of Business/Industry
36 n 72 h	olet	Elementary/Secondary (0-12) College (1-4 or 5+)	7. 1.	,	.1/4
withi withi grene her th	Completed	17. Father's Name (First, Middle, Last)	Disabled	other's Name (First, Middle, M	N/A
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medical	Be C	1 - 1 0 0 000	j.	Ethel Mae	White
	2	19a_Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and		
MD d 2 sho lth and n 27 is numation		Pauline Wright - Aun	+ 1204 Moore Ari	e. Lansdowne	DA 19050
ore, MC es I and 2 s of Health au If item 27		20a. Method of Disposition	20b. Place of Disposition (Name of cemetery crematory or other place)	1	20c. Location - City or Town, State
Pages nent of nant: I		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	Bayview Crematory	11/26/2012	Baltimore, MD
Baltimore, permit. Pages 1 at Department of He. Important: If ite		21. Signature of Funeral Service Licensee	22. Name and Address of Fa	acility March	F/H-East
00 8 9 7 1 1		Simitte K. Jmes	1101 E. North	Ave. Baltimos	e, MO 21202
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.		as cardiac or respiratory arre	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Ca			Death
		545 (5) 45 4 55 155 44	ence or):		
	Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of the conditions).	ence of):		
_	Examiner	(Disease or injury that initiated execute resulting in death). Lest be used to resulting in death. Lest	ence of):		
Tansit uted		events resulting in death) Last Due to (or as a consequence) d.			
be executed ician and inial - transi	dical	UNPENDED AMENDED			
760, cate by physic he bur	Me	IF FEMALE: 23c. If yes, outcome of			23d. Date of delivery
Box 68760 e death certificate by the attending physied for use as the bu	Physician/Me	23b. Was decedent pregnant in the past 12 months?	of death	topic pregnancy	Month Day Year
30X death e atter	ysic	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
b.O. Be that the de ned by the detached f		Part II. Other significant conditions contributing to death but	t not resulting in the underlying cause given i	in Part I. 23e. Did tol	pacco use contribute to the cause of death?
i, P.O.	d by	Acute and chronic alcohol use		1 Yes	2 No 3 Probably 4 V Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed			24a, Was a autops	
Reco The law cate has	mc			perform	
tal Recian: The certificate ector, page	Be	25. Was case referred to medical	26.Place of De	eath (Check only one)	
Vit.	0	examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatient 3 DOA Other	4 Nursing Home 5	Residence 6 🗸 Other; Scene
ing Ph After 1 funeral	L:	27. Manner of Death 1 V Natural 5 Panelina 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at V	protessioning	ow injury occurred
sion ttend death. ctor: y the f	Certification:	2 Accident Investigation	1 Yes 2		
Division pital or Attens ours after death leral Director:	tiţi	Suicide Could not be	- At home, farm, street, factory, office building	g, etc. 28f. Location (S or Town, St	treet and Number or Rural Route Number, City ate)
Dspita hours ineral		4 Homicide			
Division of Vital Records, P.O. Box 68760 within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the by	ical	(Check only one) 2 Medical Examiner: On the basis of examiner	owledge, death occurred at the time, date an ation and/or investigation, in my opinion, deat		
To t To t	Medical	and manner stated. 29b. Signature and title of certifier	29c. License num		29d. Date signed (Month, Day, Year)
	_	Canso HILDAN	O.C.M.E.		November 7, 2012
2		30. Name and address of person who completed cause of death			
5			miner 900 W. Baltimore Street, I	Baltimore, MD 21223	
St	tate	31. Date filed (Month, Day, Year) 32. Registrar's S			
Regist	trar	MON O 0 2012	And Lad		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#14perFH, G933, 11/20/2012, WS State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner EN BURNIE ANNA If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 214-46-8179 66 1 X M 2 🗆 F MD Director Yrs 08/12/1946 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director Pasadena Anne Arundel MD 1 Yes 2X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21122 602 Eliot Rd. USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2X Married ☐ Yes 2 🔀 No Specify: Whb White Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Self-employed 12 Barber n and Mental Hygien 7 is marked other the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Dolores Pardo permit. Page 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any injury or access. ည Joseph Cavanaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Eliot Rd., Pasadena, MD 21122 Kathleen Cavanaugh / Wife 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date W. Arundel Crematory 11/20/2012 odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 MO1452 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and strans Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 as signed by the attending d be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, within 24 hours after death.

To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 🗌 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital Other: ၉ 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated The last of the lasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D56854 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre 2106/ W

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ Year 2012 Nichole Covington 8:55 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Director 577-94-2204 1 □ M 2 👿 F March 23,1972 Washington, DC Usual Residence of Decedent 2 should be filed within 72 hours efter death with the Maryland th end Mental Hygiene.
27 is marked other then "naturel", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 10a, State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Prince George's Landover 10f. Zip Code 10g. Citizen of What Country? Funeral 3115 75th Avenue #102 20785 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. by Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government 2yrs Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lafayette Demory Patricia Covington permit. Page 1 and 2 should Depertment of Health end Mi Importent: If item 27 is mar eny injury or other treumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Covington/Mother 3115 75th Avenue #102 Hyattsville, MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Harmony Mem. Cemetery 11-20-2012 Hyattsville, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 7474 Landover Road Hyattsville, MD 20785 23a. Part 1. 5 ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit Hospital or Attending Physician: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 0 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 10060100 11-11-12 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THAT MINH SILVO Earl Silv Shop n 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

NOV 2 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 November 10:01 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Greater Baltimore Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 217-54-4346 1 M 2 □ F 60 Usual Residence of Decedent or then "natural", or items 23a or 28a-f show the Medical Evanniner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No timore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cubap, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: 15/ac Completed 3 ☐ Widowed 4 ☑ Divorced Maryland 21245-003 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use-retired) Elementary/Secondary (0-12) College (1-4 or 5+) revention Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, raham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Reute Number, City or Town, State, Zip Code) Orwood 000 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or (1 Burial 2 Cremation 3 Removal from State Baltimore MD 4 Donation 5 Other (Specify) 11-26-2012 Signature of Funeral Service Licenses 22. Name and Address of Facility Quehn Greene Functal Services Koaa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ SUPSIS disease or condition day Medical resulting in death) Due to (or as a consequence of): Examiner Celluliti Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and s the burial-transit Peripheral Due to (or as a consequence of): Physician/Medical Box 68760 ettending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the ercompletely filled in by the funeral director, page 2 should be detached formation. 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 1 No 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital 2 1 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 🗌 Yes 2 🗌 No 1 Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainten as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 00043489 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bohn No chanles St Parilian North 4535 32. Registrar Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Karen Madden Chaney November 2012 9:07AM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital ocial Security Number 6. Sex Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Min. Director 103-34-8676 1 □ M 2 🕅 F 68 1944 Usual Residence of Deced Pennsylvania 1 end 2 should be filed within 72 hours efter death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Marvland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12301 Braxfield Court #5 20852 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager Construction Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Michael Madden <u>Jean Wilma Muir</u> 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9920 Hellingly Place
Montgomery Village, Maryland 20886 19a. Informant's Name/Relationship (Type, Print) Brian P. Chaney/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 of Pepartment of Pepartment of Pepartment: If Its any Injury or ot once. Montgomery Crematorium, Inc. 1 Burial 2 Cremation 3 Removal from State November 21, 2012 4 Donation 5 Other (Specify) Bethesda, Maryland 21. Signature of Furtheral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 M00355 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Myocardial Infarction Medical Examiner (Lun Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): After this certificate has been signed by the ettending physicien and funeral director, pege 2 should be detached for use as the burlei-trensit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or injury that initiated events resulting in death) Last Pleural Effusion Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 5 Pending 2 Accident
3 Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) el 0748 November 15, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tet Wei Chan 8600 Old Georgetown Road, Bethesda, Maryland 20814

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 8 Year Physician/ 335 NHO 12 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A BALTIMOR LENTER ERC. M FDICAL If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign Numbe 7. Age (In vrs. last birthday) Sex 1 X M 2 ☐ F **Funeral** Country) Maryland **7**3 Months Hours Min. 220 38 9852 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director ms 23a or 28a-f s must be notified 1 Yes 2 No Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21226 U.S.A. 1525 Cherry Street items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married o. þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) n 27 is marked other than er traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Short Order Cook 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Woolford Clark Sr. Marie Ganzimiller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21226 Donna Clark / Wife 1525 Cherry Street Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11/12/2012 Baltimore, Maryland 5 Other (Specify) Cedar Hill Cemetery 4 Donation 21. Signature of Fureral Service 22. Name and Address of Facility Gonce Funeral Service, Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Puermon, A WFFK disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760 6 Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? EMPHYSEMA 1 Yes 2 No 3 Probably 4 Unknown should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has blirector, page 2 s autopsy yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ◯ No 26. Place of Death (Check only one) funeral director, Hospital: မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

7

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

20

2012

MD

Name and addless of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

DHMH 17 Rev 7/2009

54.

6430=

PAUL PL. BALTIMORE

29d. Date signed (Month, Day, Year)

2012

21201

12-08757

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

enia Dela-Cruz	1- For State Registrar	State of Maryland	Certificate		id iviental H		3. No. 201	2 3720
Physician Medical Examine	1. Decedent's Name (First	Kelila D	e La Cruz	•		Date of Death Month November		3. Time of Death 2357 hrs
mind &	4a. Facility Name (if not i	Dela Gruz institution, give street and number)			Location of Death		4c. County of Deat	h
Funeral	3949 Warner Av		e (In yrs. last birthday)	Hyattsville	ar If Under 24Hrs	8. Date of Birth	Prince Georg	
Director	074-72-2370	0 1 M 2 X F	2/.	Months Day		_	70 Forei	
any	Usual Residence of Dece 10a. State 10b.	edent County	10c. City, Town or Loc	ation				10d. Inside City Limits
Maryland 28a-f show d at once.	PA 10e. Street and Number	Lehigh	Bethleh					1 Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once.		Way		10f. Zip Code	017	10	g. Citizen of What Cou USA	intry?
or iten	3 Vidowed 4	1 Yes 2 X Divorced If Yes, Give Year or Dates:	No I	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Puerto specify:	Rican, etc.)	White, etc.	ican Indian, Black, Hispanic
7	Elementary/Secondary 12th Grade	e 4yrs.	- during	ent's Usual Occupa most of working life Teacher	o DO NOT use reti Assistar	red) lt	16b. Kind of Business. New York Schools	
21215-0036 Suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Hipolito	Dela	a Cruz		18.Mother's Name Argent	ina	Pauli	
O % 5 .a .a .	19a. Informant's Name/R Hipolito	elationship (Type, Print) Dela Cruz-Fathei		ing Address (Stre			per, City or Town, State A. 1AO17	e, Zip Code)
Baltimore, MD 2 permit Pages I and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic	20a. Method of Disposition 1	on remation 3 Removal from St	ate crematory or		- T	Date	20c. Location - City o	•
Baltimore, comit. Pages I ar Department of Her important: If ite injury or other tr	4 Donation 5 C			rove Par	The second secon	24 - 12 Vlie Fund	Hackensac eral Home	
m 립스포트 Physician	23a. Part I. Enter the dise	ease, or complications that caused			lmor Stre	et Balt:	imore, Mar	yland 21217 Approximate Interval
/Medical xaminer		e cause on each line. disease a. Oxycodone	and Ethan					Between Onset and Death
was a second	Sequentially list condition if any, leading to immedia	ate Due to (or as a cons	equence of):					
ted Insit	(Disease or injury that initiation events resulting in death	itiated C.	equence of):					9
60, ste be executed stysician and e burial - transit	X UNPENDED	d. AMENDED #1,	23a, 27, 28a-	-f.per me	,g933 11-	-29-12 s	m	
760, cate be execute physician and the burial - tran	IF FEMALE:	23c. If yes, outcor			Ectopic pregna		23d. Date of deliver	у
D.O. Box 6876 that the death certificat ned by the attending phy detached for use as the	23b. Was decedent pregn past 12 months? 1 Yes 2 No 9	Month	Day Year					
P.O. E es that the igned by the detached	3	t conditions contributing to deat	h but not resulting in the	underlying cause	given in Part I.		pacco use contribute to	the cause of death?
cords, law requir has been s 2 should t						24a. Was a autops perforr	y prior to ned? death?	utopsy findings available completion of cause of
of Vital Reciperation: The African this certificate meral director, page	25. Was case referred to examiner?	Hospital:	ent 2 ER/Outpatie		of Death (Check		Residence 6 🗸 Othe	ur: Scane
ing Phys After thi	27 Manner of Death	No 28a Date of Inju	ıry 28b. Time d	f Injury 28c. Inju	ury at Work?	28d. Describe he	ow injury occurred	. Godile
Division of Voiral or Attending Phonix after death. eral Director: After filled in by the funeral	1 Natural 5	28e Place of In	7-12 fd 11 :	40 рш —	Yes 2 X No	unknows		ural Route Number, City
Division O E Hospital or Attending 24 hours after death. e Funeral Director: Aftered filled in by the fune	3 Suicide 6 3		und at hom			or Town, St	ate) 3949 War Hyattsvill	ner Ave.
Division To the Hospital or Attention within 24 hours after death To the Funeral Director: completely filled in by the		fying Physician: To the best of m ical Examiner:On the basis of exa and manner stated.						
H S H S	29b. Signature and title o			29c. Licen	se number .M.E.		29d. Date signed (Mo	
		f person who completed cause of c				lakima:- ASS		
Stat		y, Year) 32. Registra	ledical Examiner		more Street, E	aitimore, ML	1 2 1 2 2 3	
Registra	NOV 2	0 2012 Senera	B. par					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1139 AM 2012 Rachel Read Cruzan November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinou Hospital of Baltimore Baltimore City Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) Director 212-30-2943 1 □ M 2 🗓 F 82 Nov. 15, 1930 Maryland It of Health and Mental Hygiene.
If Item 27 is marked other than "natural", or Items 23a or 28a-f shov or other traumetic event, the Modical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 XNo Timonium Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21093 12261 Roundwood Road #420 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 x Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Public Schools Teacher Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Marie Brooke Folline William Wigg Hazzard Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Private Drive #64, Proctorville, OH 45669 Mary Leslie Radcliff/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it 1 Burial 2X Cremation 3 Removal from State 11/21/2012 Bel Air, Maryland Rose Hill Svcs. LLC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee lessee Ludaver 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. a. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Intra cramial Physician/ homoroticae disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertension 15 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation on anticoagulation 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Sam. (ES - 000 November 16, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 West Belvedere Avenue Sinai Hospital of Ballimore BASU, MBBS ARNAB Baltimore, MD 21215 31. Date filed (Month, Day, Year) NOV 2 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FRANCIS BERNARD CAVEY, JR. Month 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death FRANKLIN Sa iase Rosedal Baltimor = HOSPITal 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 218-52-0992 Usual Residence of Dece 1 M 2 🗆 F 12-31-1948 MARYLAND 10a State 10h County 10c. City, Town or Location with the Maryland !7 Is marked other then "netural", or items 23a or 28a-f sho treumatic event, the Marilds Exam<u>iner must be notified at</u> 10d. Inside City Limits Director MD. BALTO. **ESSEX** 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1925 SUE CREEK DRIVE 21221 USA death \ Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced and Mental Hygiene. Is marked other then "netural", Completed Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
THOMAS CAVEY \$ SON (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) INSURANCE AGENT **INSURANCE COMPANY** 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Importent if item 27 is marked any injury or other treumanions. မ FRANCIS B. CAVEY, SR. BETTY LOU WEBSTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCIS B. CAVEY, SR **FATHER** 1200 MARYWOOD DRIVE BEL AIR, MD. 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MORELAND MEMORIAL 11-19-2012 PARKVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BEL AIR 610 W. MACPHAIL ROAD BEL AIR, MD. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Intracrania Hemorrhag disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a considuence of burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 2 No Yes 2 No 1 Yes Hospital or Attending Physician: 24 hours after death. Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after dea... el Director: Afte 1 Natural
2 Accident
3 Suicide (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-15-2012 D64480 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR musta Fa H. Fidahussein 9000 FRANKLIN Square DR Balto md 32. Registrar's 6ignature State

DHMH 17 Rev 06-2011

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Fannie Chapman Nov 10, 2012 1:17p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore Joseph Richey Hospice, Inc. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours Director 215-24-6059 1 🗆 M 2 🗂 F May 22, 1922 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Me Acal Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD **Baltimore City Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2800 East Coldspring Lane 21214 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc δ 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2 No Specify: Specify: Black 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) t of Health and Mental Hygiene. If item 27 is marked other tha Housekeeping Fort George G. Meade Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ 1 and 2 should be Hayward Andrew Isabella Andrew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2800 East Coldspring Lane, Johnnie Jowers Baltimore, Maryland 21214 Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If i any injury or c Page 1 Department of 1 X Burial 2 Cremation 3 Removal from State **Garrison Forest Veterans** Nov 27, 2012 Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical ed by the attending physl detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnan Ectopic pregnancy in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) 2 4 o ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 🗌 Yes 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of death?

1

✓ Yes 2

No 24a. Was an After this certificate has autopsy within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence မှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manne of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred ✓ Natural 5 Pending 2 Accident
3 Suicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 32. Registra State Registrar

		101	partment of Health and Mer ertificate of Death	Reg. No. 20 2 3721
Physicia Medio	cal	1. Decedent's Name (First, Middle, Last) JOSE PHINE COLLINS		Date of Death Month Day 16 7012 3. Time of Death O100 A
Examin	ier	4a. Facility Name (if not institution, give street and number) NOTHWEST HISPITEL	4b. City, Town, or Location of Death Randall StauN	Baltimore
Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last birthda</i> 471−20−4941 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs.</i>	y) If Under 1 Year If Under 24 Hrs. 8. 1 Months Days Hours Min. Ja	Date of Birth Month, Day, Year, 1924 9. Birthplace (State or Forei Country) Minnesota
the Maryland a or 28a-f show be notified at	Funeral Director	10e. Street and Number	Location Reisterstown 10f. Zip Code	10d. Inside City Limi 1 ☐ Yes 2 🛣 10g. Citizen of What Country?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland peprmit. Page 1 and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funera	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No 1f Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. De	21136 3. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rical I Yes 2 No Specify: cedent's Usual Occupation ve kind of work done during most of working	Yes or Non, etc.) 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business Industry
2 should be filed within 72 h and Mental Hygiene 7 is marked other than " traumatic event, the Med	e Con	12 College (1-4 or 5+)	Director	Day Care Center
l be filec lental H rked ott tic even	To Be	17. Father's Name (First, Middle, Last) George Hachey		st, Middle, Maiden Surname) gnes St George
should th and M 7 is ma traumal		19a. Informant's Name/Relationship (Type, Print) 19b. M.	ailing Address (Street and Number or Rural Ro	ute Number, City or Town, State, Zip Code)
permit. Page 1 and 2 should be filed Department of Heath and Mental His Important; If item 27 is marked oth any injury or other traumatic event once.		20a. Method of Disposition 1	sposition (Name of Date rematory or other place)	sterstown, MD 21136 20c. Location - City or Town, State
permit. P Departm Importar any injur		21. Signature of Funeral Service Licensee	Cremation, Inc 11/17 22. Name and Address of Facility 118 ELINE FUNERAL HOME Re	324 Reisterstown Road
Medical Examiner Examiner E burial-transit	lical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		
sician: The law requires that the death certificate Ecertificate has been signed by the attending physirector, page 2 should be detached for use as the E	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
equires that the sen signed by could be detaction	ted by Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow
The law n cate has b page 2 st	Comple	·		24a. Was an autopsy performed? 1 □ Yes 2 □ W 1 □ Yes 2 □ W 2 □ W 1 □ Yes 2 □ W 1 □ Ye
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the I	To B	25. Was case referred to medical examiner? 1 Yes 2 1 No 27. Manner of Death 1 Deatural 5 Pending 2 Accident Investigation 2 No 1 No 28a. Date of injury (Month, Day, Year) 28b. Time injure 28b. Time injure 28c. Date of injury (Month, Day, Year)	5 Residence 6 Other (Specify) Describe how injury occurred	
vital or Att urs after d ral Direct	al Certi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	<u></u>	Location (Street and Number or Rural Route Number, City or Town, State)
he Hosp in 24 ho he Fune pleted fi	Medic	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, deal carbon the basis of examination and/or involved the basis of examination and or involved the basis of examinati	estigation, in my opinion, death occurred at the t	ime, date and place, and due to the cause(s) and manner st
To the within com		29b. Signature and title of certifier M M M M M M M M M M M M M	29c. License number 08162650	29d. Date signed (Month, Day, Year) NWPMW1 16 2012
•		30. Name and address of person who completed cause of death (Item 23a) (Type Guver (Jub) 5401 21d (Jun+		
l		31. Date filed (Month, Day, Year) 32. Registrar's Signature		Pri citi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death R 15 2012 Physician/ NOVEMBER 5:47 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTE TOWSON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** (Month, Day, Year) New York 218-46-0603 1 MM 2 🗆 F 63 Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Baltimore Lutherville 1 Yes XX No 10e. Street and Number 10g. Citizen of What Country? Funeral 93 U.S.A. urnberr 210 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Plant Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Campagna, Jr. Biasotti Betty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Turnberry Ct., Lutherville, MD 21093 Betty Boniecki -mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 Durial 2 X Cremation 3 Removal from State Hilltop Serv Corp 11/16/12 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Rd. Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Acute Physician/ ena Medical resulting in death) Examiner Failure Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transil bleeg Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy eral Director: After this certificate I filled in by the funeral director. Daos 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month. Day, Year) 2012 D0057619 and address of person who completed cause of death (Item 23a) (Type, Print) TREE Rd Ste. 420 (Month, Day, Registrar

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Medic Examin		4a. Facility Name (if not institution,	give street and number)		4b. City, Town, or Location of De				4c. County			ath
<u> </u>		Hebrew Home of 5. Social Security Number					Rocku-		0 D-4(Did			ntgomery
Funeral Director		217-47-4000	6. Sex 1 X M 2 D F	e (in yrs. ia	st birthday) Yrs.	Months Days	Hours		8. Date of Birl (Month, Da April 2	n X Year) 5 , 1	1923 9. BI	irthplace (State or Foreign ountry) Russia
and show	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or L	ocation						10d. Inside City Limits
Maryl 28a-f lotifie	irec		tgomery				Roci	kvill	e.			1 ☐ Yes 2 🌠 No
with the s 23a or ust be n	Funeral Director	10e. Street and Number 12630 Veirs Mi	ll Road. #90	19		10f. Zip Code	2085.	3		10g. C	Citizen of What C	S.A.
r death or items oiner m	y Fun	11. Marital Status 1 □ Never Married 2 🌠 Marr	12. Was Decedent F Armed Forces? 1 \(\sum \) Yes 2 \(\sum \)	Ever in U.S	13.	. Was Decedent of Hi If Yes, specify Cuba	spanic Orig n, Mexican	gin? (Spec n, Puerto R	ify Yes or No- ican, etc.)		14. Race - Am Black, Whi	
urs afte :ural", c	ted by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	NO		1 ☐ Yes 2 🛣 No	Specify:				Specify:	White
72 ho n "nat Aedica	Completed	(Specify only highe	t's Education st grade completed)		(Give	edent's Usual Occupa e kind of work done d DO NOT use retired)		t of working	g	16b.	Kind of Business	Industry
within giene. er tha		Elementary/Seconday (0-12)	College (1-4 or 5 5 +	5+)			sicis	t		P.	rofesso	r/Education
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, L Yefi	_{ast)} m Chernomoro	lik			18. Mothe		(First, Middle, phir Kr		n Sumame) ovskaya	
should and N is ma aumat		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mai	ling Address (Street a	nd Numbe	er or Rural	Route Numbe	r, City o	or Town, State, Z	ip Code)
and 2 : Health em 27 ther tr		Victor Chernomo 20a. Method of Disposition	rdik - Son	20h D		adburn Cou	vrt, i					
Page 1 anent of I ant: If ite		1 【X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Ce	emetery, cre	position (Name of ematory or other plac Gardens		_	/2012		Location - City o Lkville,	Maryland
permit. Departi Import any inji		21. Signature of Funeral Service Li	icensee	mi	>	22. Name and Addres						l Home, Inc.
		23a Part 1 Enter the disease, or shook, or heart failure. List o	complications that cause								ver spr	Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Der	nent	ia							Onset and Death
Examiner		Sequentially list conditions,	Due to (or as	a consequ	ence of):							
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To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	☐ Ectopic pregnanc☐ Other (specify)	у				23d. Date of de Month	elivery Day Year
that the	by Ph	Part II. Other significant conditio	ns contributing to death b	ut not resu	ulting in the	underlying cause giv	en in Part I	l.	23e. Did to	bacco	use contribute t	o the cause of death?
quires en sig ould be	ted t								1 🗆 '	Yes 2	2 M No 3 □ F	Probably 4 🗌 Unknown
e law re s has be ge 2 sh	Completed							_	24a. Was autop perfo		prior to death?	utopsy findings available completion of cause of
an: The tificate tor, par	Be Cc	25. Was case referred to medical				26. Pla	ace of Deat	th (Check o	1 \(\superset \text{Yes}\)	2 🔯 N	No 1 ☐ Y∈	es 2)X No
hysicii nis cer i direc	To B	examiner? 1 Yes 2 No	Hospital:	ent 2 🗆 I	ER/Outpatie	ent 3 DOA Othe	r.			lence	6 ☐ Other (Spe	cify)
nding Pl tth. : After the e funeral		27. Manner of Death 1 💆 Natural 5 🗆 Pending 2 🗀 Accident Investig			28b. Time o injury	work'			3d. Describe h	ow inju	ry occurred	
l or Atter after des Director	Certificate:	3 Suicide 6 Could r 4 Homicide determi	me, farm, st	treet, factory, office		2	8f. Location (S City or Tow			ural Route Number,		
Hospita 24 hours Funeral eted fillec	Medical	(Check 2 Medical E		xamination	and/or inve	stigation, in my opinio	n, death oc	curred at the	he time, date a	nd plac	e, and due to the	cause(s) and manner stated
To the within To the Comple	Σ	29b. Signature and title of certifier	Nurse Practioner: To the	best of my	knowledge,	29c. License	number			29d. Da	ate signed (Mont	th, Day, Year)
3./		30. Name and address of person w	who completed cause of d	M	antro	Print)		ckvi	211-	MI		
Stat	e	31. Date filed (Month, Day, Year)	0 2012 32. Redistre	's Signatu	ure		100		I VICE	100	V ~ 4	
Registra	ır	NOV 2	0 2012	w	B. 17	parke						

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Pritam K. Dang Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TOWSON BALTIMORE SAINT JOSEPH MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 220-45-2708 Director 78 1 □ M 2 🛛 F Sept 28, 1934 India Usual Residence of Dece permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at another. 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? by Funeral 2 Dalecrest Court Apt. 104 21093 India 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Asian Indian 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jot Singh Sapra Rampiari Sapra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Inderjit Sehdev, Daughter 8705 Marburg Manor Drive Timonium, MD 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. 11/15/12 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INTRACEREBRAL HE MORR HAGE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has hear sinned by the control of the attending physician and chec for use as the burial-tran-Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?
☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) |2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS 7601 OSLER DRIVE TOWSON, MARYLAND 21204 KHOO M.D.

A DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amela Daiutolo	0	Redistrar	artment of rtificate of		and	Mental	Hygiene	Reg. No.	201	2 3721
Physici ledical Exami		Pamela D'Aiutolo					2. Date of D Month Novemb	Day Der 15, 20	Year 12	3. Time of Death 1757 hrs
		Facility Name (if not institution, give street and number) 6130 Lawyers Hill Road		4b. City, Tow Elkridge		cation of De	ath		ounty of Dea ward	th
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. la 215-52-5133 1 M 2 F 6.		If Under 1 Months	Year Days	If Under 24		Birth(MM/DD 7 / 1 948		Sirthplace (State or seign Country) Illinois
I OW ADY		Usual Residence of Decedent	Town or Locat		d					10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show ootified at once.	Director	10e. Street and Number		10f. Zip Co				_	n of What Co	untry?
death with the Maryland or items 23a or 28a-f shu must be cotified at once	Funeral D	6130 Lawyers Hill Road 11. Marital Status 1 Never Married 2 Married Armed Forces?			of Hispai		Specify Yes or rto Rican, etc.)			States erican Indian, Black,
F ~	Ď	3 Widowed 4 Divorced of Yes (Give Year or Dates: 1. Yes 2 No of Yes (Give Year or Dates:) 15. Decedent's Education (Specify only highest grade completed)	1 16a. Deceden		cupation	(Give kind			ecify: d of Busines:	White s/Industry
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e, MD and 2 shore Health and litem 27 is retraumatic	-	Paul D'Aiutolo / Husband 20a. Method of Disposition 20b. F	1913 Place of Dispos	Fleet	Str	eet,]	Baltimor Date	e, Ma	ryland	
Baltimore, MD 21215-0036 Pepernit. Pages 1 and 2 should be filed within 72 hours after Department of Filed and Mondal Hygience, If item 27 is marked other than "outural", iojury or other traumatic eveot, the Medical Examiner.		Tomoral Tomoral Tomoral	crematory or other Crest Tor Crest 22. N	matory	Inc	. 11 FacilityCr	/17/201 emation	2 Bal Socie	timore	e, Maryland Maryland In
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50, te be executed ysician and burial - transit	edical Examiner	events resulting in death) Last Due to (or as a consequence of d. X UNPENDED X AMENDED 23a, 27, p		933 1	1-28	-12 si	m			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	ΣI	#\$ner Fh IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregritude by the pregnant at time of dealers.	ath 2 Fe	tal death	3	VS Ectopic pres			Date of delive onth	Day Year
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n of Vit diog Physic 1. After this of funeral dire	은	1 Yes 2 No Indian 1 Inpatient 2 27. Manner of Death 1 X Notice (Month, Day, Year)	ER/Outpatient 28b. Time of Ir	njury 28c.	Injury a	t Work?	sing Home 5		e 6 🗹 Oth	er: Scene
Division of Vital Records, P.O. To the Hospital or Atteodiog Physiciao: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	Certification:	Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	me, farm, stree			2 No	28f. Location or Town		Number or F	Rural Route Number, City
o the Hospi vithin 24 hou o the Funer	edical C	29a. Certifier 1 Certifying Physician: To the best of my knowledg one) 2 Medical Examiner: On the basis of examination are and manner stated.	ge, death occur nd/or investigati	red at the tim	ie, date a	and place, a	nd due to the ca d at the time, da	use(s) and n	nanner as sta , and due to t	ated. the cause(s)
	M	29b. Signature end title of certifier Caral Hall du			.C.M.				e signed (M nber 16, 2	onth, Day, Year) 2012
		30. Name and address of person who completed cause of death (Item Carol H. Allan, MD Assistant Medical Examiner	900 W. E	Baltimore :	Street,	Baltimor	e, MD 2122	3		
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	South	1						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland	nd / Department of Health and Mental Hygiene						
			1 - State Registrar		Certificate of Death	Reg.	No.2012	37217			
т	Dhysisis	/	1. Decedent's Name (First, Middle, Las	t)	* .	2. Date of Death		3. Time of Death			
	Physicia Medi		Walte	r Lerou	Dimes	November	Day Year /6, 2013	2 9:32 AM			
	Examin		4a. Facility Name (if not institution, give	street and number)	4b. City, Town, or Location	of Death	4c. County of Death				
			4705 Picke	tt Court	Suitlar	nd	Prince 6	Teorges			
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last b	Months Days Hours	24 Hrs. 8. Date of Birth	9. Birth	pplace (State or Foreign			
	Director		213-37-2797	15	Yrs. World's Days Frodis	Min. (Month, Day, Yea March 27	1937 W	aryland			
	nd how	<u>-</u>	Usual Residence of Decedent 10a, State 10b, County	10c City To	wn or Location			10d. Inside City Limits			
	arylar a-fs fied	Director	Maryland Prince	Seorges S			-	1 🗆 Yes 2 🗷 No			
	or 28		10e. Street and Number	100	11 + 1an a	100	Citizen of What Cou				
	with t	ra	4705 Picke	tt Court	20740		115 E	1			
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Ori	gin? (Specify Yes or No-	14. Race - Ameri	Ican Indian			
9	or it	by	1 Never Married 2 🔀 Married	Armed Forces? 1 ☒ Yes 2 ☐ No	If Yes, specify Cuban, Mexican	n, Puerto Rican, etc.)	Black, White,				
8	ırs af ural", I Exa		3 Widowed 4 Divorced	If Yes, Give Year or Dates. 1960-1962	1 ☐ Yes 2 🗷 No Specify:		Specify:	acK			
5-0	2 hou "natu dica	Completed	15. Decedent's Ed (Specify only highest gra		Sa. Decedent's Usual Occupation (Give kind of work done during mos	t of working	. Kind of Business Ir	ndustry			
21	within 7 giene. ler than t, the Me	E O	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO NOT use retired)		. 1 . 1				
2	d wit lygie ther nt, th	Be C	12		Truck Drive			unty Schools			
anc	be filed ental Hy ked oth ic event	10 B	17. Father's Name (First, Middle, Last) Leonard	N:		er's Name (First, Middle, Maide		1			
ž	should be filk and Mental I 7 is marked or raumatic eve			Dimes		hectte	Washi	1.			
Maryland 21215-0036	2 shou th and 27 is m traum		19a. Informant's Name/Relationship (Ty		9b. Mailing Address (Street and Number		The second second	1 22241			
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		tannie A. Dim 20a. Method of Disposition		1705 Pickett (111(0311)				
Baltimore,	Page 1 nent of ant: If it ury or o		1 🔀 Burial 2 🗌 Cremation 3 🗍	Removal from State cemer	tery, crematory or other place)	11/01/00/01 -	. Location - City or T	1.			
亞	permit. Page Department Important: any injury o		4 Donation 5 Other (Specification 1)		tico National Cemetery		riangle,	Virginia			
$\mathbf{B}\mathbf{a}$	permit. Departr Importa any inju		21. Signature of Funeral Service Licens	B-1. 01	22. Name and Address of Facilit			2			
			23a. Part 1, Enter the disease, or comp	lications that caused the death. Do		gton Road Arling	Nn, Va. 22				
ı,	and the same		shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.	secure	cardiac of respiratory arrests	22	Approximate Interval Between Onset and Death			
	Pnysician/∘ .∂ Medical		disease or condition resulting in death)	a Corcir	roma lu	19		Oriset and Seath			
عميدا	Examiner			Due to (or as a consequence	e or);	U					
5		Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	e of):						
X	ansit	Examiner	if any, leading to immediate	_							
20	exect an an rial-tr	ĕ	that initiated events resulting in death) Last	Due to (or as a consequence	e of):						
09	ate be executed physician and the burial-transit	edical		d							
876	tificat ng ph as th	Mec	IF FEMALE:								
Box 687	h cer tendi r use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal dea	ath 3 Ectopic pregnancy		23d. Date of deliv	· ·			
Bo	deat he at led fo	/sic	1 Yes 2 No	4 ☐ Pregnant at time of death 9 ☐ Unknown			Month	Day Year			
0	at the d by f etach	by Physician/Me	Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause given in Part	00- Pid t-1	o use contribute to t	h			
Division of Vital Records, P.O.	res th signe I be d	d b	3		g with and and onlying dadde given in Part	3		babiy 4 Unknown			
ğ	v require s been si should b	Completed				/ \					
000	has b	ld m				24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of			
ř	r. The		OF MC			performed?	No 1 Yes	2 No			
Ita	siciar certif recto	Be	25. Was case referred to medical examiner?	lospital:	Other:	h (Check only one)					
<u>></u>	Phys this ral di	2	1 Yes 2 No	1 Inpatient 2 ER/C	Outpatient 3 DOA Other 4 Nu Time of 28c. Injury at	rsing Home 5 Residence		0			
0	ding th. After fune	Certificate:	1 Natural 5 Pending	(Month, Day, Year)	injury M 1 Yes 2	28d. Describe how inj	ury occurred				
Sio	Atten dear ctor: y the	ij	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, f		28f. Location (Street a	and Number or Pura	l Poute Number			
<u>></u>	l or / after Dire		4 ☐ Homicide determined	building, etc. (Specify)	,,,,	City or Town, Sta		rioute Number,			
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Phys	cian: To the best of my knowledge	, death occured at the time, date and p	place, and due to the cause(s)	and manner as state	ed.			
	ne Hk in 24 ne Fu pleter	Med	(Check 2 L Medical Examir	er: On the basis of examination and	/or investigation, in my opinion, death oc wledge, death occurred at the time, date	curred at the time, date and plan	ce, and due to the ca	use(s) and manner stated.			
	Vithi Vot		29b. Signature and title of certifier	1 ~	29c. License number	29d. E	Date signed (Month,				
				pro o	D4647	8 111	-16-201	2			
	ച		30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print)						
	70		Suresh	A - Patel mo	7501 Surro	1tts Rel, CI	inton.	MD20735			
	Stat		NOV 2 0 2012	32. Regis ar's Signature	e d						
	Registra	1	NUY & U ZUIZ /	12 . 14 man							

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		For State	State of Mar	yland /					and N	lental Hy	giene			
		Registrar	04)		Cert	ificate	of L	Death_			Reg. No.	20	12	37218
Physicia Medic		1. Decedent's Name (First, Middle, La	Mack	Dan	ile	15				2. Date of Dea	Day	5 Y	ear 12	3. Time of Death
Examin	er	4a Facility Name (if not institution, give to rest Have)		of the	me	4b. City, To	lc	Location of	of Death	e	40	County of	Death	more
Funeral Director			Fex 7. Age (In	74		If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birl (Month, Da Jun	h 20, 193	38	9. Birthp Count	lace (State or Foreign ry) MD
aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County MD Baltin	nore City	Oc. City, Tow	n or Loca	ation		Balti	more			I	11	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
ith the Ma 23a or 28 st be noti	ral Dire	10e. Street and Number 1633 Laurens Street			10f. Zip Code 10g. Citizen o								n of What Country?	
ems ar mus	Funeral	11. Marital Status	12. Was Decedent Ever	rin U.S.	13. W	as Deceder	nt of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	Т	14. Race -	America	an Indian.
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Inpegratment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	امَ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.			Yes, specify Yes 2			, Puerto	Rican, etc.)		Black, Specify:	White, e	
2 hou "natu	plet	15. Decedent's E (Specify only highest gr		16a		ent's Usual of			of worki	ng	16b. Ki	ind of Busi	ness/Inc	dustry
d within 7 ygiene. her than nt, the Me	Be Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		Ìife. DO	NOT use re	etired)	reman					U S Gypsum Supply	
Ild be filed Mental H Narked ot naric ever	To B	17. Father's Name (First, Middle, Last) Jesse Daniels						18. Mothe	er's Name	e (First, Middle, Ma		Surname) a Daniels		
nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relationship (7 Reginald Daniels	ype, Print)	191		Address (S McCuli				Route Numbe Baltimore,			e, Zip C	ode)
Page 1 a nent of H ant: If ite ury or ott		20a. Method of Disposition 1	Removal from State	20b. Place o cemete Garr	ery, crema	atory or oth	er place			Date 2012		ngs]	-	
permit. Departr Importa any inji		21. Signature of Funeral Service Licen	Ele							l Service, I imore, Md				
Physician/ Medical		23a. Part 1. Enter the disease, or comshock, or heart fallure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.			1					rest,			Approximate Interval Between Onset and Death
Examiner	iner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury) Local Control Co										>	Hyrs	
be executed sician and burial-transit	cal Examiner													
ficate g physas the	/ledi		d.								ì			
To the Hospital or Attending Physician: The law requires that the death certificate be executer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans.		in the post 12 months? 1 Live Birth 2 Lifetal death 3 Liectopic pregnancy							23d. Date of Month		ry Day Year			
uires that the signed by uld be deta	ed by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing 1 ☐ Yes 2X No 3												
The law rec ate has bee page 2 sho	Completed by									24a. Was autop perfo 1 Yes		prio dea	re autop or to con ath? I Yes	osy findings available inpletion of cause of
cian: ertific ector,	B	25. Was case referred to medical examiner?	Hamital				_	ice of Deat	h (Check					
Physic this c	P.	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of injury		utpatient			4 Nu		me 5 Resid			Specify)	
ttending death. tor: After the fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Ye	ear) i	injury	М			No	28d. Describe h				
oital or Ai urs after ral Direc illed in by		4 Homicide determined	28e. Place of Injury - building, etc. (S	pecify)						28f. Location (S City or Tow	n, State)			
the Hosp hin 24 ho the Fune upletely f	Medical	(Check 2 Medical Examonly one) 3 Certifying Nur	sician: To the best of my iner: On the basis of exam se Practitioner: To the be	ination and/o	or investig	ation, in my leath occurr	opinion red at th	n, death oc ne time, dat	curred at	the time, date a	nd place,	and due to	the cau	se(s) and manner stated.
viti To		29b. Signature and title of certifier						number				e signed (A		Day, Year)
16	-	30. Name and address of person who	completed cause of death	n (Item 23a) ((Type, Pri		203	3330			//	(4/1-		
K.	1	John E.	Tokes 1V	11h										
State Registra	- 1	31. Date filed (Month, Day, Year)	32. Registrar's		Med	,								

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G935, I/30/2013, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1750 M Lovember Laola Dixon-Brown Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death a If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Country) Director 1 □ M 2 1 F 09/18/1938 Maryland 28a-f show 2 should be filed within 72 hours after death with the Maryland that and Mertal Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shortraumatic event, the Medical Examiner must be notified at traumatic event, 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X☐ Yes 2 ☐ No MD Queen Anne's Oueenstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 211 Olde Point Lane 21658 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ☐ Never Married 2 🔀 Married Black, White, etc. þ 1 Yes 2 No If Yes, Give 1 ☐ Yes 2 ¥☐ No Specify: 3 Widowed 4 Divorced Specify. Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Bank Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be Department of Health and Mer Important. If item 27 is marke any injury or other traumatic Robert Chanev Helen Gist 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Dixon / Son 1715 Lansford Avenue, Dallas, TX 75224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/20/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ metastate Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I After this certificate has been signed funeral director, page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ပ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann Death 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practitioner to the best of my knowledge and at the time, date and place, and deate the a 29c. Libense number 29b. Signature and title of certifie address of person who comp f death (Item 23a) (Type, Print) vahus DINUMO 31. Date filed (Month, Day, Year) State 32. Registra s Signature NOV 2 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State	of Marylan		artment of F		and Me		- (201	2 3	372	20
Physici	an/	1. Decedent's Name (First, Middle	, Last)						2. Date of De		Vea		Time of D	eath
Med Exami	ical	Shirlene 4a. Facility Name (if not institution,	give street and num		oggett	t Novemb					2, 201 County of De		2:05	Рм
		Keswick Rehabi	litation	Center		Baltimo		Deam		40.	Jounty of De	eatn		
Funera Director		5. Social Security Number 240–44–5337	6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Bin (Month, Da	y, Year)		Country)	(State or F	
nd now at		Usual Residence of Decedent 10a, State 10b, County		87	Yrs. y, Town or Loc	- tion			Sept.	11, 1	925 No		Caro	
/larylar 8a-f st tified a	recto	Maryland			timore	cation							nside City X Yes 2	
h the A ka or 2 be no	al Di	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What	Country?		
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36 after de ", or its		1 Never Married 2 Marri	Armed Fo	rces? 2 X No	If	Vas Decedent of Hi Yes, specify Cuba		, Puerto Ri	can, etc.)		4. Race - An Black, Wh	ite, etc.	dian,	
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Saltimore, bermit. Page 1 and Department of Hea mportant: If item any injury or other		20a. Method of Disposition	3 ☐ Removal from		lace of Dispos emetery, crem	sition (Name of atory or other place	e)	Dat	te	20c. Loc	ation - City o	or Town, S	State	
baltimor permit. Page 1 Department of Important: If it any injury or c		4 Donation 5 Dother (St. 21. Sign ature of Funeral Service Li	pecify			norial Ce				_	land N	Weck,	NC	
Dalti permit. Departr Imports any inji		X Jenen	retter		Me 55	Name and Addres tropolit 17 Vine	an Fu	neral Alexa	Servi indria,	ice VA	22310			- 1
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quires that i		Part II. Other significant condition	ns contributing to de	eath but not resu	ulting in the un	derlying cause give	en in Part I.	_			contribute t			
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or Attending Physician: The la after death. Director: After this certificate he din by the funeral director, page	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Othor	ce of Death	(Check or						
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1			>	EM		Doo	5405	2		11	12/12			
HV		30. Name and address of person with Dalket Salu	ocompleted cause	of death (Item :	23a) (Type, Pri	nt)	- SE	C	ist 1	vy 2	4211			
Stat	е	31. Date filed (Month Day Year) NOV 2 0 2012	Server 32. Re	gistra 's Sign	ale	nt) 200								
Registra	al .		/	,										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle_Last) 2. Date of Death 3. Time of Death Physician/ EDWARDS 10SEPHINE 8-40A M 2012 Medical 4b. City, Town, or Location of Death Examiner ndallstown Dattimore JOSPICE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Months Min **Director** filed within 72 hours efter death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Saltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral rring 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 No 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT, use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' ondary (0-12) College (1-4 or 5+) nitoria Be 18. Mothe 's Name (First, Mode, Maiden Surname) ၉ ones Odress (Street and Number of Rura Route City of Town, State, Zip Code) 21215 arrington more Soad 3altimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other pla Date 1 Burial 2 Cremation 3 ò emoval from State any injury o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OBSTREICTION BOWEL Physician/ MARI disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): is certificate has been signed by the attending physician end director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant Day Month Pregnant at time of death 5 Other (specify) Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy 2 No Yes 2 N 25. Was case referred to medical examiner?

1 Yes 2 No Da lei Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence & မှ Hofnice 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No □ Accident Investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier 29c. License number D28595 sirleu WW) 30. Name and address of person who completed cause of death (Item 23a) (Type, Pript) PO DOX 1221 DWINGS MILL ASNEEM mi 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State NOV 2 0 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4:49 A M 20 (2) lorda Gawards Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glynn Taft Assisted Living Catonsville Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) 216-14-8056 Director 90 1 M 2 XF Maryland 23 192 Usual Residence of Dece 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Baltimore Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a 21234 8730 Cimerron Circle United States 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White "natural" Completed 3 X Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h ige 1 and 2 should be fik nt of Health and Mental I :: If item 27 is marked o ည Joseph Corman Marie Dorsch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9934 Evergreen Avenue Columbia, MD 21046 Robert Edwards-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November Date Page 1 a Department o Important: If any injury or 1 X Burial 2 Cremation 3 Removal from State P Lake View Menorial Park 4 Donation 5 Other (Specify) Sykesville, Maryland 20, 2012 of Funeral Service Licensee Sig 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
8800 Harford Rd. Parkville, MD 21234 nt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between diate Cause (Final Onset and Death Physician/ olon caucer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Records, P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Winknown ie Heart Failur peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy performed Yes 2 4 funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASS/5+40 Las 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation
6 Could not be Accident completely filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 11-17-2012 aves D1966 e down 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 508 Olece Bring Q 31. Date filed (Month, Day Year) NOV 2 0 2012 32. Registrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOSEPH WILLIAMS EVANS Medical NOVEMBER 2012 3:15P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6412 EVERALL AVENUE BALTIMORE N/A Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. (Month, Day, Year) Director 219-32-5277 1 ☑ M 2 □ F 75 Yrs JUNE 20,1937 MARYLAND or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County filad within 72 hours aftar dagth with tha Maryland 10c. City, Town or Location Director 10d. Inside City Limits N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6412 EVERALL AVENUE 21206 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ai Hygiana. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) DRIVER OIL COMPANY 8TH Be other traumatic event, parmit. Paga 1 and 2 should ba fliad Dapartment of Haaith and Mantal Hy Important: If Item 27 Is marked oth any hijury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CLAYTON EVANS RUTH MCDONALD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS M. EVANS **SPOUSE** 6412 EVERALL AVENUE BALTIMORE, MD. 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 X Other (Specify) ENTOMBMEN GARDENS OF FAITH 11-16-2012 BALTIMORE, MD. 21. Signature of Tune ServiceRicensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, 6415 BELAIR ROAD BALTIMORE, MD. 21206 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) INUY arm Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine e Hospital or Attanding Physician: The law requires that the death cartificate be axecuted the hours after death.

Fueral Director: After this cartificate has been signed by the attanding physician and lataly filled in by the furnarial director, page 2 should be deteched for use as the burial-transit attanding physician and I for usa as tha buriai-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month 1 Yes 2 l 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 23e. Did tobacco use contribute to the cause of death? Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical within 24 hounded the Funer completely file 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatu 29d. Date signed (Month. Dav. Year) DZ8949 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANAYTOTIS BALTATZIS 8113 HARFORD ROAD SUITE 100 PARKVILLE, MD. filed (Month, Day,

DHMH 17 Rev 06-2011

Registrar

32. Registra

NOV 2 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month THOMAS EDWARD EVELYN 6:30 A. M Medical NOVEMBER 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 508 WYCLIFF COURT HARFORD 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 216-24-0194 Days Hours (Month, Day, Year) Min. Director 1 **X**M 2 □ F 83 Usual Residence of Decedent 2-24-1928 <u>ALABAMA</u> . Pege 1 and 2 should be filed within 72 hours efter death with the Maryland ment of Health end Mental Hyglene. Itans to terms 23a or 28a-1 show tant: If item 27 is marked other than "natural", or items 23a or 28a-1 show jury or other traumatic event, the Madical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits HARFORD MD. **JOPPA** 1 🗌 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 508 WYCLIFF COURT 21085 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Anned Forces? Black, White, etc. <u>۾</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: 3 Widowed 4 Divorced Completed Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) BRICKLAYER CONSTRUCTION 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ ALLAN EVELYN **NONA GUY** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS D. EVELYN SON JOPPA , 508 WYCLIFF COURT MD.21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any injury or o 1 🗆 Burial 2 🟝 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-19-2012 GLEN BURNIE, MD. ATLANTIC CREMATORY Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD NOTTINGHAM, MD.21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or conditi-resulting in death) HRTERY ORONARY Medical Due to (or as a consequence of): [']Examiner MUPERLIPIDEA MIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as of the cause (Disease or injury). Examine Due to (or as a consequence of) ASBESTUSIS signed by the ettending physicien and d be deteched for use as the burlel-trensif To the Hospital or Attending Physician: The law requires thet the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete hes autopsy 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical å 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 🗌 Yes 2 🗆 No 5 Pending injury veral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours at To the Funeral D completely filled i Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie D41080 11/16 MAD 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) E. CHURCHVIUE Rd. BEZAIR Md. 21014. HRCHANA 208

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State Registrar 31. Date filed (Month, Day, Year) NOV 2 0 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Erline Month 5:00P November 2017 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 24 Kintore Court Parkville Baltimore Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign (Month. Day, Year) Director 215-34-1271
Usual Residence of Deceder 1 M 2 TS F 73 Yrs 02/10/1939 MD il Hygiene. I other than "natural", or items 23a or 28a-f show vent, the <u>Medical Examiner must be notified at</u> 10a. State 10b Count 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4845 Greencrest Road 21206 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ♣ No Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give 3 Midowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Administrative Secretary American Red Cross Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any oriant: If other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Richard Raab Elizabeth Bauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Kintore Court Parkville, MD 21234 Mary Colacioppo, Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State Holly Hill 11/17/2012 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death a Metastate AdenouncemaniA OF UNKILOWN ORIGIN Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to milinediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? performe 2 🗌 No Yes 2 No 1 Yes Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 □ No မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending s after death. 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital of within 24 hours at To the Funeral D completely filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinin NS/LAY

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State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State State Certificate of Death Reg. No. 2012 3722												
			Registrar 1. Decedent's Name (First, Middle, Last)	Cei	illicate of Dea		2. Date of Dea	Death 3. Time of Death				
	Physicia Medic		ESTHER E	NGILISH			₩ ^{bth} V	Day 2012 1:30 P M				
3	Examin		4a. Facility Name (if not institution, give street and number	r)	4b. City, Town, or Loca			4c. County of Death				
and the	Funeral		AUGSBURY LUTHERAN 5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	BALTIM If Under 1 Year I If U		8. Date of Birth	irth 9. Birthplace (State or Foreign				
	Director		212-32-9259 1 D M 2 🕮 F	77 Yrs.	Months Days Ho	ours Min.	11/18/1	934	Country) VA			
pu	at	o.	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation				10d. Inside City Limits			
Maryla	28a-f s	rect	MD BALTIMORE	PIKESVILI	LE				1 🗆 Yes 🚈 No			
th the	3a or 2 be no	al Di	10e. Street and Number		10f. Zip Code			10g. Citizen of W	hat Country?			
ath wil	ems 2	Funeral Director	6811 Campfield Road 11. Marital Status 12. Was Decede	nt Ever in U.S. 13. V	21207 Vas Decedent of Hispan	nic Origin? (Spec	ify Yes or No-	USA 14. Bace	- American Indian,			
land 21215-0036 be filed within 72 hours after death with the Maryland	, or it		1 Never Married 2 Married 1 Yes 2	es?	Yes, specify Cuban, Me ☐ Yes 2 👿 No Sp	exican, Puerto R	ican, etc.)		, White, etc. WHITE			
-000	atural' cal Ex	Completed by	3 Widowed 4 □ Divorced If Yes, Give Year or Date	3.	ent's Usual Occupation							
215	e. nan "na Medi	ldmo	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4	(Give k	ind of work done during ONOT use retired)		g	16b. Kind of Business/Industry GBMC HOSPITAL				
d with	Hygiene other the	Be Co	12 17. Father's Name (First, Middle, Last)	CLI	ERICAL							
Baltimore, Maryland 21215-0036	ental F ked o		ELMER LEONHARDT		BE BE	ATRICE	SCHREIN	Maiden Surname) IER				
Maryland	and Mi is mar aumat		19a. Informant's Name/Relationship (Type, Print) ALICE CLARK-DAUGHTER	19b Mailin	Address Steet AVE	Jumber or Petral	Rayta Humbay	— 1Ď ^{ty} 2 Ĩ23 Å ^{ta}	ate, Zip Code)			
e, R	lealth am 27 her tra			20b. Place of Dispos		1			Oc. Location - City or Town, State			
mor Page 1	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from St	5/12	BALTIMORE, MD							
Baltir permit. P	Department of Important: If ii any injury or o once.	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME									
മ ഉ	8 5 5 5		Stefamio Kinet	~]	415 BELAIR			MD 2120	06			
11-5	estation is		23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each Immediate Cause (Final	line.	1 11				Approximate Interval Between Onset and Death			
) N	/sician/ Medical		disease or condition	LDSCLERONE as a consequence of):	L UIRGIN	011150	ELMAS	Dize	126			
Ex	aminer	<u>.</u>	Sequentially list conditions, b.									
pa	nsit	Examiner	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of,					<i>P</i>			
execul	ohysician and the burial-transit	I Exa	that initiated events resulting in death) Last C. Due to (or	as a consequence of):								
60 ate be	physicia the bu	dical	d									
687 Sertifica	attending ph I for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outco	me of <u>pr</u> egnancy				23d. Date	e of delivery			
Box 687 death certifica	e atter	Physician/Me	in the past 12 months?	nt at time of death 5	Ectopic pregnancy Other (specify)			Mon				
at the	been signed by the s should be detached		9 Unknown Part II. Other significant conditions contributing to dea		nderlying cause given in	Part I.	23e Did to	hacco use contrit	bute to the cause of death?			
Records, P.O. The law requires that the	signe Id be c	Completed by	CHRONIL DESTRUCTIVE			SASE			3 Probably 4 Unknown			
ord w requ	s beer 2 shou	plete	CONGESTIVE HERR	T FAILU	RE		24a. Was a	in 24b. W	ere autopsy findings available rior to completion of cause of			
Red The la	this certificate has ral director, page 2	Com	CHRONIC RENAC INSUPPICIONEY autopsy prior to completion areause of death? 1 Yes 2 No									
/ital sictan:	certific) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital:		Other:	of Death heck		о П оч	(0, 11)			
of V	ter this neral d	te: To	27. Manual f Death 28a. Date of	oatient 2 ER/Outpatien injury 28b. Time of Day, Year) injury	28c, Injury at work?			ence 6 Other ow injury occurred	· · · · · · · · · · · · · · · · · · ·			
ion	tor: Aff the fu	Certificate:	2 Accident Investigation		M 1 Tyes							
Division of Vital talor Attending Physician:	Direct of in by			Injury - At home, farm, stre , etc. (Specify)	eet, factory, office		City or Town		r or Rural Route Number,			
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier Certifying Physician: To the bes (Check 2 Medical Examiner: On the basis	of examination and/or invest	igation, in my opinion, de	eath occurred at t	he time, date ar	nd place, and due	to the cause(s) and manner stated			
o the l	omplei	Me	only one) 3 Certifying Nurse Practitioner: To 29b. Signature and title of certifier			ne, date and plac	e, and due to the	ne cause(s) and ma				
) 	> P= 0		Fasiem Xall	lan nu) D28	Stall	1	Whet	12			
			30. Name and address of person who completed cause TASNEEM LAKHA	of death (Item 23a) (Type, P	P-DBOx 1	525 (DWIN	as M	ILL MD 21117			
	Stat Registra	e		istrar's lignature	1							
			A. A									

DHMH 17 Rev 06-201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Worth ember Year **Physician** laymond Francis 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 **x** M 2 □ F Months Days Director 218-68-8483 Dec. 15,1955 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show Examiner must be notified at 1 Yes XX No Director MDBaltimore Edgemere 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? items 23a or 4527 Green Cove Circle 21219 Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 XVo
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2X No Specify: ò 3 Widowed 4 Divorced Year or Dates: White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Transportation other than Elementary/Secondary (0-12) College (1-4 or 5+) Authority 12 Years Sergeant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Fisher of Is marked of J. D. Francis JoAnne Jaffray ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau once. 4527 Green Cove Circle Edgemere, Maryland Mrs. Patty Ann Francis(Wife) 21219 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gdns. of Faith Cem. 4 ☐ Donation 5 ☐ Other (Specify) 11/21/2012 Baltimore, Maryland 21. Signatur / Funeral Service Licensee Greco 22. Name and Address of Facility E. Reed Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart ailore. List only one cause on each line. Approximate Interval Between Onset and Death-Immediate Cause (Final ASCVD Physician ong Steading disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listage Central Indicated events resulting in death) Last Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-trans resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical as attending IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗌 No 2 7 certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient မ 3 DOA After this 28d. Describe how injury occurred 27. Manger of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: 1 Natural
2 Accident (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death uneral Director: / 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 1 🂢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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11595

State Registrar

31. Date filed (Month, Day, Year) NOV 2 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pantle, Mo 32. Registrar's Signature barres

Hardin

D-0061115

November 17, 2012

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29c per dvr g933 II-20-12 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William Martin Forster Sr. 16 2012 6:30 P November Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 217-14-3751 Director 1 X M 2 □ F Feb. 4, 1922 Maryland 90 ar than "natural", or itams 23a or 28a-f aho the Medical Exeminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No Maryland Harford Joppa 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 1507 Philadelphia Road 21085 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumeth. Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4 or 5+) Insulator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Belle Lewis Charles (unk) Forster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna J. Forster / Wife 1507 Philadelphia Road, Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date parmit. Page 1 a 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. 11/21/2012 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. Jessea Lukava 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Bue to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burlal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Day Year ☐ Yes 2☐ No signed by the a 9 Unknown Part II. Othe icant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy performed cartificata 1 ☐ Yes 2 ☐ No 2 - No 26. Place of Death (Check only one) of Vital funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည this To the Hospital or Attending Ph within 24 hours after daath.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Matural 2 ☐ Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Division Investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 VCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Pay, Year) 29c. License number w 500 upper chesapeake or 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIM Bel Air Mb 21014 31. Date filed (Month, Day, Year) NOV 2 0 2012 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 2:20 PM eano Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death hma zenesis Himone 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday **Funeral** MD Country) Months Hours 1 M 2 😾 02^M21, 13924 219-16-3537 88 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 Yes 2X No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral USA 21234 8720 Emge Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 K No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. White Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Federal Government Secretary 12 Be 18. Mother's Name (First, Middle, Maiden Surname)
Florence M. Wendel 17. Father's Name (First, Middle, Last) James S. Calwell Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8515 Rally Ct. Colorado Springs, CO 80920 19a. Informant's Name/Relationship (Type, Print) Judith A. Gillispie- Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Baltimore National Cem 11/19/12 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Sin all re of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. Baltimore, 19705 Belair Rd Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conse un nce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exam Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy Live Birth 2 Fetal death 3 in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death the 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page 2 within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 2 No 2. 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 12 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Werthfring Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of deruffie 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) 30. Name and address 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 2:55 PM **Physician** 2012 Louis M. Fratta 11 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Square tospita ranklin Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 83 Yrs. **Funeral** Days Months Hours Min 13€ M 2 □ F 06/06/1929 220-24-3986 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Madical Exp., per man be notified at 1 ☐ Yes 2√ No Director Baltimore Middle River 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 21220 10015 Ichabod Ln. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No
If Yes, Give 1951-53
Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 21⁄2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, It a Medic once. College (1-4or 5+) Elementary/Secondary (0-12) Sales and Repairs Television Technician 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Erminia Tosches Teodore Fratta ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10015 Ichabod Ln. Middle River, MD 21220 Mary Fratta- Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore City St. Stanislaus Cem. 11/19/2012 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Schimunek Funeral Home Inc. Nottingham, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, de heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hemoschage baracho /Medical Due to (or as a consequence of): Examiner pertension Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Yeer in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only within 24 and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 32. Registra's Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive Baltimore MD 21237 Soon

DHMH 17 Rev 1/2001

State

Registrar

Date filed (Month, Day, Year)

NOV 2 0 2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Novembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** -678 1 1 M 2 - F Days Months Hours Min. (Month Day, Country) -62 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 72 hours after death with the Maryland 10c. City. Town or Location notified at Director 1 Yes 2 No JWYNN 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? ō "natural", or items 23a or edical Examiner must be Funeral 2120 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Stics 1anaqei tationes 12 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) should be file and Mental F is marked of Hields မ permit. Page 1 and 2 should be Department of Health and Men: Important: If item 27 is marke any injury or other traumatic to anci lames 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address, Street and Number Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of 20c. Location -City or Town, State Date cemetery, crematory or other place 1 Burial 2 Termation 3 Removal from State Baltimore 20/2012 4 Donation 5 Other (Specify 21. Signature of Funeral Servi e li ensee 22. Name and Address of Facility ttoru Ma Heig te, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as derdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardian Immediate Cause (Final Pchem C Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): g physician a Physician/Medical Box 68760 inding pure as as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Pregnant Unknown signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Onknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 Natural injury 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director, of the formula of the formu 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MP 11-19-2012 D-38754

DHMH 17 Rev 7/2009

Registrar

MALIKA

31. Date filed (Month, Day, Year) NOV 2 0 2012

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32. Registrar's S

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M.D. 2(221

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WASZEM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Month 5:58 PM 2 Year 1 Physician/ 101a Clara Medical 4a. Facility Name (if not institution, give street and number)
2503 Benton Court 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Churchville Har tord If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2**XX**F **Director** 235-20-8524 94 JUNE 21,1918 WEST VIRGINIA Usual Residence of Decedent show 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a, State Director be notified 28a-f 1 Yes 2 No CHURCHVILLE HARFORD MARYLAND 10a. Citizen of What Country? or 10f. Zip Code 'natural", or items 23a Funeral U.S.A. **Examiner must** 2503 BENTON CT 21028 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 14 Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married within 72 hours after 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE 3 XWidowed 4 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12)
12TH. GRADE College (1-4 or 5+) OWN HOME HOMEMAKER Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ LIGGETT UNKNOWN SHREVE CHARLES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau CHURCHVILLE MD 2503 BENTON CT. SHAY/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 11/17/2012 GLEN BURNIE MD ATLANTIC CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign to of Fineral Service 22. Name and Address of Facility
SCHIMUNEK FUNERAL HOME OF BEL AIR, INC.
610 W. MACPHAIL RD., BEL AIR MD 21014 23a. Part 1. Enter the disease of complications that Gaussian List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between nset and Death Immediate Cause (Lina disease years arter Physician! Coronary disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) physician and s the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 38 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 Yes 2 No 3 Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy has performed death? 1 Tyes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 🛂 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ြု 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at n 24 hours after death.

Funeral Director: After the Certificate: 5 Pending Natural work?
1 Yes 2 No Investigation 6 Could not be Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check EMERGENCY PHYSICAN 29C. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ASST. MED DIR. HARFORD EMS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel Air MD 21014 500 Upper Chesapeake Dr. Chizmar m.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 2 0 2012 Registrar

DHMH 17 Rev 06-2011

State Registrar

(Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

ORIGINAL

2835

Smith Av

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4b. City, Town, or Location of Death 4a. Facility Name if not institution, give street and number) 4c. County of Death Examiner Baltimore Randallstown <u>Seasons Hospice</u> at Northwest Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year, 8/24/1924 Country)
Maryland Days Min. 217-18-3341 Director 1 □ M 2 😾 F Show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If item 27 is marked other then "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location Director 1 X Yes 2 ☐ No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 USA 3551 Wilkens Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 A Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Factory Manual Labor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Louise Wolfe Luther Huxter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3551 Wilkens Ave., Baltimore City, MD 21229 Judith Foard 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/19/2012 Baltimore, MD New Cathedral Cem. 21. Signature of Fundal Service Licenses 22. Name and Address of Facility Ambrose Funeral Home 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Cause (Disease or injury that initiated events resulting in death) Last 흔 Due to (or as a consequence of) Exami to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 2 🗌 No Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital suttent hospice Other: 1 Yes 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Mann 1 Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tit ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

2134 Baltimore, Maryland 21215-0036 Kincoln Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Lincoln Fleermuys 2134 M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Shady Grove Adventist Hospital 9. Birthplace (State or Foreign Country) 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🛣 M 2 🗆 F Months Hours (Month, Day, Year) 12 Maryland None Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director notified 28a-f Rockville 1X Yes 2 No Maryland Montgomery 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? "natural", or items 23a o Funeral 198 Halpine Road. #1276 20852 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 - Widowed 4 - Divorced Black the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) None None. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Menta Melintha Fredericks Floris Fleermuys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trau once. 198 Halpine Road, #1276, Rockville, Maryland 20852 Floris Fleermuys - Father 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 11/20/2012 Brentwood. Maryland . Signature of Funeral Service Licens 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center M. Neva 1040 Rockville Pike, Rockville, Maryland 20852 M01621 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Chario amnionitis Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or se's consequence of) attending physician and for use as the burial-transit law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 1 Yes 2 9 Unknown 2 🗆 No been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 Hospital or Attending Physician: The I 24 hours after death.
Funeral Director: After this certificate h sted filled in by the funeral director, page 2 🗌 No 1 🗌 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🐪 No Hospital 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death

1 Matural
2 Accident
3 Suicide
4 Homicide 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital of within 24 hours a To the Funeral D completed filled is Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

Registrar

9711 medical

Rockville.

Cdr Dr # 109

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Henry W. Feindt 11:40 PM November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Lutherville Timonium Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Funeral 218-12-2463 **Director** 1 🛛 M 2 🗆 F January 11, 1922 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show empirity or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Maryland Harford 1 Yes 2 No Fallston 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral 21047 1516 Ryan Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Date \$7/09/1942 Specify: Caucasian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Dentistry Dentist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Frederick Feindt Marie Carolyn Becker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VOVEMBER 1516 Ryan Road Fallston, MD 21047 Deborah A. Martz / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov 26, 1 A Burial 2 Cremation 3 Removal from State Dundalk, MD 4 Donation 5 Other (Specify) Holy Rosary Cemetery 21. Signature of Funeral Service Ligensee m00933 22. Name and Address of Facility volou Kaczorowski Funeral Home, P.A. 1201 Dundalk Avenue Baltimore Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Betwe Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physiclan: The lew requires that the death certificate be executed Cause (Disease or injury the attending physician end ched for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? has been signed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 Director: After this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21093 JUSTINE PREIS, CRNP 2300 DULANEY VALLEY ROAD TIMONIUM MD

State Registrar 31. Date filed (Month, Day, Year)

62. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 8, per fh. g933 11-27-12 sm State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 201 3. Time of Death Physician/ Month alle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Aruna Baltimore Washington Medical Center Glen Burnie 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month) Day, Birthplace (State or Foreign Country) **Funeral** Hours **ւ** 2 □ F Director 01 or 28a-f show 10c. City, Town or Location filed within 72 hours after death with the Maryland must be notified at Director 1 🗌 Yes 2 🔀 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 725 204th Street 21122 **USA** 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. þ 1 ☐ Yes 2 💢 No If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify White 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meonee. Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Sanitation 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Calvin Page 1 and 2 should be 1 nent of Health and Menta L. Geyer Doris Barry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen L. Geyer 725 204th Street, Pasadena, MD 21122 (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery Ž012 Glen Burnie, Maryland 4 Donation 5 Other (Spg Signature of Funeral Service L 22. Name and Address of Facility ne and Address of Facility Stallings Funeral Home, 1 3111 Mountain Road, Pasadena, MD 21122 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of) disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed cholesterol attending physician and for use as the burial-tran Due to or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) F FEMALE: 23h. Was decedent pregnant 23d. Date of delivery in the past 12 months? 2 No signed by the a 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à obstructive pulmonary 1 Yes 2 No 3 Probably 4 Unknown Completed Cerebrovuscular disease Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has becommletely filled in by the funeral director, page 2: autopsy Vascular Aprile and periphera disease 1 Yes 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 140 Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 DER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tasadena WD 31139 effrey Atkinson M.D. 8028 Ritchie Highway 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 9:20 Lucy A. Gentry-Roy November 15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Owings Mills 14 Buhrstone Court 8. Date of Birth (Month, Day, 3-6-1920) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. 217-22-4737 Director 1 □ M 2 😾 F NC 92 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MD Baltimore Owings Mills 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a or Funeral 21117 USA 14 Buhrstone Court or items permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Specify: African-American 3 X Widowed 4 ☐ Divorced Year or Dates. 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Tech Assistant Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Edward M. Forest Lucy Ann France 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Buhrstone Ct., Owings Mills, MD Franklin Dyson/GrandNephew 20a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge Cemetery 20c. Location - City or Town, State 11-21-2012 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ (blow Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 res, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 X No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 2 🗌 No Accident Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: The law requires that the death certificate be executed No the.

within 24 hours after co...

To the Funeral Director: Afte

Medical 2 Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only or 29b. Signatı and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D007128= 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

#4105, Balthuore, MD 21204

4 Homicide

29a. Certifier

determined

State Registrar 6701 N. Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PAULETTE ORANT 10 55 PM NOV Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner CHENT 4c. County of Death PALTIMORE UNIVERSITY OF MARY LAND MEDILA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 218-64-1454 Months Days Hours (Month, Day, Year) Director Usual Residence of Deced Show 10a. State 10b. County 10c. City, Town or Location the Maryland event, the Medical Examiner must be notified at Director 10d. Inside City Limits 28a-f 1 ☑ Yes 2 ☐ No MA imore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with 23a U5A 21239 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 6 Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: "natural" Completed 3 Divorced ac Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life, DQ-NOT use retired) during most of working and Mental Hyglene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) lailer Be 17_Eather's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ည ames 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Poute Number, City or Town, State, Zip Code) item 27 hwal Baltimore MD 21239 nrous 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any Injury or otl once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) US 11-24-2012 Vinore MD 22. Name and Address of Facility Va uahn C. GREENC FUNCTAL Services 21. Signature of Funeral/Service Licensee Himory MD 21212 Juse 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ RESPIRATORY FAIWRE disease or condition resulting in death) Medical Examiner BASAL GANGUA Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). physician and the burlal-transit or Attending Physician: The law requires that the death certificete be executed Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Box 68760 attending pt IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day or: After this certificate has been signed by the the funeral director, page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, NONE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ٩ Other: 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death,

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 06-2011

(Check only one) 29b. Signature and title of cer-

NATASHA

MD

32. Registrar's Synature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANSR

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

22 SOUTH, OREENE STREET

AU4176435#1975

29d, Date signed (Month, Day, Year)

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BALTIMORG

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Ì	20a. Method of Disposition 1 □ Burial 2 【 Cremation 3	Demoved from State		lace of Dispo	osition (Name of matory or other place		Date	1	tion - City o	Town, State	
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permit. Departi Import any inj		21. Signature of Funeral Service Lice			22 I	2. Name and Addre	ss of Facility neral I	Home of D	ulanev	Valle	ev. Inc.	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2 Medical Exa	nysician: To the best of miner: On the basis of urse Practioner: To the	examination	n and/or inves	stigation, in my opini	on, death occur	rred at the time, date	and place, an	d due to the	cause(s) and manner sta	ated.
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UM		30. Name and address of person who	o completed cause of c	leath (Item	23a) (Type, I	Print)	20015	mu z	1220			
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 17, 2012 7:12 A M MARY ANNA GRZYMALA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TIMONIUM STELLA MARIS HOSPICE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min (Month, Day, Year) 213-32-2150 Director 1 ☐ M 2 🛣 F 80 Yrs 4/25/1932 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, <u>the Medical Examiner must be notified at</u> 10d. Inside City Limits Directo TIMONIUM MD BALTIMORE 1 Yes 2 XNo 10f. Zip Code 21093 10e. Street and Number 10g. Citizen of What Country? 2300 DULANEY VALLEY RD Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ð Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: WHITE Completed 3 √2 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER permit, Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>trans injury or other traumatic event</u>, <u>trans injury or other traumatic event</u>, to be the traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 BARBARA PRELLER JOSEPH PANUSKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zio Code) 8704 SILVER KNOLL DR PERRY HALL, MD 21128 MADONNA HOLMES-DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/21/12 BALTIMORE, MD HOLLY HILL MEM'L CEM. 21. Signa ure of Fune al Service Licenses 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME NOTTINGHAM, MD 21236 BELAIR RD 3a/ art 1 Eprer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) ☐ Yes 2X No g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an performed? Yes 2 K No Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 X No ရု 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 **K** Other (Specify) **HOSPICE** 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and titl

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2300 DULANEY VALLEY RD.

son who completed cause of death (Item 23a) (Type, Print)

(Month. Dav. Year)

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0819 arcia to Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Balkmore Pitz 101 If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Director 214-44-0506 1 X M 2 - F 08/19/1945 67 Marvland Page 1 and 2 should be filed within 72 nous and 1 should be filed within 72 nous and 1 should health and Mental Hygiene.
Trant: If item 27 is marked other than "natural", or items 23a or 28a-f show trant: If item 27 is marked other than "matural", or items 23a or 28a-f show than "filed 21 show that the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21231 U.S.A. 143 N. Patterson Park Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. à 1 Never Married 2 Married American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Completed Indian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Healthcare Geriatric Nursing Assistant Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renardo Fisher / Son Baltimore, MD 21231 Patterson Park Avenue, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Cher (Specify) Anatomy Gifts Registry 11/19/2012 Hanover, Maryland Anatomy Gifts Registry 21. Signature of Funeral Service License 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examin or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day 5 Other (specify) Month signed by the and be detached for Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) **Division of Vital** Hospital: 2 No Other: 1 Yes မှ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time date and place.
3 Certifying Nurse Practitioner: To the best of my knowledge. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 10c,e,f per fh g933 11-20-12 vt

State of Maryland / Department of Health and Mental Hygiene

state per fh g933 11-29-12 vt

Registrar

Per fin g933 11-29-12 vt 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Etya Gurevich 4:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery Date of Birth (Maria, Pay, Year) 1920 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Country kraine 216-23-9100 **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b, County 10d. Inside City Limits 10c. City, Town or Location **Funeral Director** 1 Yes 2 □ No MD Montgomery Silver Spring Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 6105 Montrose Road 20906 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Professor Education 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Moisey Gurevich Maryam Flus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alla A. Balannik / Daughter 2107 Carriage Square Place, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/19/2012 Beltsville, MD Chesapeake Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 9 Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phy ici Congestive Heart Failure With Severe Aortic Stenosis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Chronic Renal Failure Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or the attending physician and hed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav 5 Other (specify) Pregnant at time of death 9 Unknown g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Anemia of Chronic Disease 2 No 3 □ Probably 4 □ Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) mina D 0064871 11.17.2012 30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print) MI Road, Rochville, MD 20852 31. Date filed (Mont State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gudrun Martha Gsell Month Vear 12:00 PM Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brighton Gardens Columbia Columbia Howard 5. Social Security Number 8. Date of Birth (Month, Day, Year) 04/09/1929 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 9. Birthplace (State or Foreign Days Months Hours Min. **Director** 1 1 M 2 X F 523-52-3097 Germany 83 Yrs Usual Residence of Dece ed other then "neturel", or items 23e or 28e-f show event, the Medical Examinar must be notified at 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits with the Maryland **Funeral Director** 1 X Yes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7110 Minstrel Way 21045 end 2 should be filed within 72 hours after death 'Heeth and Mental Hygiene. I ten 27 is marked other then "neturel", or items then treumatic event, I'm Medical Exercite man 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' rmed Forces.
☐ Yes 2 📈 No Completed by Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☑ No Specify. Specify 3 → Widowed 4 □ Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Karl Leonhard Lvdia Winterle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance Gsell-Simon / Daughter 6146 Roxbury Avenue, Springfield, VA 22152 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Importent: If it any injury or o once. 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/17/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ushell Doute ! le Dorota Marshall S Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease of injuly) Alzheimer's Disease Examine Due to (or as a consequence of): burial-transit that initiated events Due to (or as a consequence of): spitel or Attending Physicien: The law requires that the death certificete be excours after death.

Insre! Director: After this certificate hes been signed by the ettending physician iflied in by the funeral director, page 2 should be detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Atrial Fibrillation 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 횬 1 🗌 Yes 2 🗹 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Y Other (Specify) 455 isted link 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospitel of 24 hours at Funerel D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I within 2 Certifying Nurse P ictitioner. To the bast of my knowledge, death occurred at the time, date and place, and due to the nausele) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) mo D 56531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li., M.D., 8600 Snowden River Pkwy., #301, Columbia, MD 32. Registrar's signature 31. Date filed (Month, Day, Year) State NOV 2 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Herbert Leonard Gardiner A^{M} 2012 Medical 9:15 Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 07/25/1949 **Funeral** 9. Birthplace (State or Foreign Days Hours Min. Director 1 M 2 □ F 256-72-5567 63 Georgia Usual Residence of Decede 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner invest be notified at Paga 1 and 2 should ba filad within 72 hours aftar death with the Maryland mant of Haaith and Mantai Hygiena. 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13355 Rushing Water Way 20874 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian δ 1 Never Married 2 Married Black, White, etc. timore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify. Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other Truck Driver <u>Transportation</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ferd Gardiner Maybell Emmett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any Injury or other tronce. Holly Gardiner / Daughter 13355 Rushing Water Way, Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🔯 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 11/19/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility it llaishall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Éxaminer titi Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying igned by tha attanding physician and ba datachad for usa as tha burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Yes 2 9 Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Vinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Aftar this certificata has To the Hospital or Attending Physician: Tha I. within 24 hours after death. To the Funeral Director: Aftar this certificata h iabetes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? 2 KNo 1 🗌 Yes ည Other: 1 DInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) complataly fillad in by tha funeral 27. Manner of Death ë 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Ratural 2 Accident 5 Pending Certificat 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D686 58 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 medical 32. Registrar's State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ November 5, 2012 9:35 Ам Billy Gray Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 2130 Brooks Drive #502 Forestville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6, Sex 1 M M 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Ma(York Divoyear) 1931 81 Michigan Director 375-26-5179 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Forestville 1 XYes 2 No 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 2130 Brooks Drive #502 20747 be filed within 72 hours after death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Data Analyst Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Millicent Jackson permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Richard Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annette Taylor - Sister 1000 W. Hillsdale Street, Lansing, MI 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurian 2 Cremation 3 Removal from State cemetery, crematory or other place) 11-17-2012 5 Other (Specify) Evergreen Cemetery Lansing, Michigan 4 Donation Sign ture of Inneral Service Li 22 Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between YUCATOIR Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) DISERSE Examiner () LONDIO Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown significant conditions contributing to death but not resulting in the underlying 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 🛚 No Other: 1 🗌 Yes ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director; After 1 X Natural (Month, Day, Year) 5 Pending To the Hospital or Attendir within 24 hours after death.
To the Funeral Director, Af completed filled in by the fu 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 3 ☐ Sulciue 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗌 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Month Physician/ 9:25P BERNARD VICTOR GERBER Medical NOV. 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 220-14-0018 85 1/2/1927 MD 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f HARFORD HAVRE DE GRACE 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 23a 112 PARADISE DRIVE 21078 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner Black, White, etc. þ 1 Never Married 2 X Married XX Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 🗙 o Specify. "natural", Completed 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) CHEMICAL ENGINEER DEPARTMENT OF ARMY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JOSEPH **GERBER** SARAH Department of Health and M Important: If item 27 is man any injury or other traumat once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ETHEL GERBER/WIFE 112 PARADISE DR; HAVRE DE GRACE, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Donation 5 Other (Specify) WORKMAN CIRCLE 11/19/2012 BALTIMORE, MD 21. Signature of Funeral Service Licensee 800420355 SOL LEVINSON & BROS., INC. May Le 8900 REISTERSTOWN RD; BALTIMORE, MD along ter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Immediate Cause (Final schemic Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Bernard Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an nis certificate has t il director, page 2 s autopsy performed? Yes 2 No 2 No 1 Yes e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Tes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 1 Natural 5 Pending work?
1 Yes Accident
Suicide 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely i Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated pertifying Nurse Pactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title

DHMH 17 Rev 06-2011

Registrar

5

11/15/112

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesc pecke DR Port Despired Port

11/16/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November JOAN GREENWELL MAE 3:40 AM 2017 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospita N/A Baltimere Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 216-32-4375 Director 1 □ M 2 🂢 F 78 17,1933 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 X Yes 2 No N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? Funeral 977 FELLS STREET 21231 U.S.A. ıral", or items 2 Examiner muş 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black White etc. 1 Never Married 2 Married Completed by 1 Yes Maryland 21215-0036 1 Yes 2 X No Specify: "natural", 3 Widowed 4X Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) event, the DOMESTIC 12 HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental | ပ္ WILLIAM WEHNER t. Page 1 and 2 should be rtment of Health and Mer rtant: If item 27 is marke BLANCHE REESE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. THOMAS MACE/BROTHER 977 FELLS STREET, BALTIMORE, MARYLAND 21231 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MOST HOLY REDEEMER 11/19/12 BALTIMORE, MARYLAND THETE Addess ZETTER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTO., MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or a a consequence of): Examiner days Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law has autopsy performed? Yes 2 No of Vital filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ျှ 1 Yes Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred □ Matural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. d title of certifiel 29d. Date signed (Month, Day, Year) NP1-1-1710235684 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, Baltimore 900 Caton Naresh Bhandar 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 0 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

a Hill	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Registrar	012 3724
Physician/ ledical Examiner	1. Decedent's Name (First, Middle, Last) 2. Date of Death	3. Time of Death 1852 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1602 Vincent Court Apt 2 4c. County Baltimore	y of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. B. Date of Birth (MM/DD/YY) Months Days Hours Min.	9. Birthplace (State or Foreign Country)
Maryland 28s-f show any 1 at once.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. Street and Number 10c. City Town or Location	10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once at Director		Vhat Country?
p, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-fahe traumatic event, the Medical Examiner must be notified at once To Be Completed by Furneral Director		ce - American Indian, Black, ite, etc.
5-0036 ed within 72 hours stygiene. other than "nature the Medical Exami		Susiness/Industry
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat injury or other traumatic event, the Medical Exa To Be Completed	James Hill Mary William	S
e, MD 21 I and 2 should Health and Me item 27 is ma	Mon. Ka H 1 2845 (Satchouse Dr. Balt) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location	mae, MD
Baltimore, permit. Pages 1 ar Department of He Important: If ite	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Himno MD
M 월 전 및 III	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or h failure. List only one cause on each line.	eart Approximate Interval Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Mixed drug(Cocaine, Morphine, and Methadone) Intoxicat Due to (or as a consequence of):	ion Death
ed nsit Examiner	Sequentially list conditions, If any, leading to in modete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
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of Vital Records, of Physician: The law require ther this certificate has been signeral director, page 2 should b n: To Be Completed	25. Was case referred to medical 26. Place of Death (Check only one)	death? 1 Yes 2 No
ing Physician After this certi uneral directo	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA Oute4 Nursing Home 5 Residence 6	
Division o spital or Attending tours after death. neral Director: Aft filled in by the func Certification:	1 Natural 5 Pending Investigation 2 Accident Provided Investigation Investigation Pending Investigation Investigat	d drugs
Divi spital or hours afte neral Dir / filled in	3 Suicide 6 Could not be determined 4 Homicide Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could not be determined (Specify) Fd: Residence 29a. Certifier 4 Could no	ber or Rural Route Number, City Vincent Ct.apt 2
	(check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated.	
S	29b. Signature and title of certifier 29c. License number 29d. Date sig	ned (Month, Day, Year) r 11, 2012
	30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar	31. Date filed (Month, Day, Year) NOV 9 0 2012 Registrar's Signature	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20⁴12 Lawrence Holmes November 8:20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours (Month, Day, Year) Director 230-70-0458 1 🕅 M 2 🗆 F 54 Nov. 6, 1958 West Virginia Usual Residence of Decedent show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene.
The file at 15 is marked other then "natural", or items 53a or 28a-f shoo other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Kilgore 228 Court 2**1**085 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Š 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Salesman Liquor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Holmes Lois Sloan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Holmes / Brother 2365 Woodsfield Ln. NE, Marietta, Georgia 30062 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 11/19/2012 | Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland Inc 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Exa Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Linknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the tipe, date and place, and due to the cause(s) and manual as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ncholes 3+ Suite 4105 ARATHI K 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

NOV 2

	Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. AMEND ITEM#8perFH, G933, II. 2972012, WS State of Maryland / Department of Health and Mental Hygiene														
	1 - State Registrar Certificate of Death									Reg. No. 2	012	37251			
ı	Physicia Medic		1. Decedent's Name (First, Middle	1		15 Zol	3. Time of Death 2 4 53 P M								
	Examin	er	4a. Facility Name (if not institution	Hospita	re street and number), 4b. City, Town, or Location of Death HOSPITAICENTEV RAMAILSTAWN								4c. County of Death Rac I+(Move		
	Funeral Director		5. Social Security Number 212-34-3435	6. Sex	7. Age (In yrs. last birthday) F 76 Yrs. The funder 1 Year If Under 24 Hrs. 8. Date of Birthday) Months Days Hours Min. Month, Days Hours Min.								hplace (State or Foreign untry) MD		
	yland -f show ed at	Director	Usual Residence of Decedent 10a. State 10b. County MD Balt	imore		Town or Loc							10d. Inside City Limits 1 ☐ Yes 2 🏋 No		
	th the Ma 3a or 28a t be notif	ral Dire	10e. Street and Number 79 Featherbed La			160	10f. Zip Co	de 21117			10g. Citizen	of What Co			
980	e filed within 72 hours after death with the Maryland thylgiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 Never Married	12. Was Decedent E Armed Forces? 1 X Yes 2		l I	Vas Decedent Yes, specify	Cuban, M	exican, Puerto	ecify Yes or No Rican, etc.)		Race - Amei Black, White ecify: Afri			
21215-0036	nin 72 hou ne. :han "natu e Medica l	Completed	15. Deceder (Specify only higher Elementary/Seconday (0-12)	+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) Security Guard 16b. Kind of Business Indu										
land 21	ould be filed within of Mental Hygiene. marked other thai matic event, the M	To Be C	12 17. Father's Name (First, Middle, L	ast)		Secur.	ity Gtal	18.	Mother's Nan		Union Memorial Hospital First, Middle, Maiden Surname) od				
~	2 shouth and the and t		19a. Informant's Name/Relations! Glenda Harrod/ Wil			Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) atherbed In., Owings Mills, MD 21117					o Code)				
Baltimore,	nit. Page 1 and artment of Heal ortant: If item 2 injury or other e.		20a. Method of Disposition 1 Description 2 Cremation 2 Cremation 2 Cremation 2 Cremation 3 Country 3	3 ☐ Removal from State Specify)	20b. Pla	metery, crem vnsville	sition (Name of natory or othe e Vetera	place) NS	11-27		Grownst	- '	4D		
Balt	permit. Page 1 Department of Important: If any injury or once.		21. Singure of Juneral Service L	icens R	-					ie Funer: 11stown,			Balto. Co.		
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	Medical Examiner		resulting in death) Sequentially list conditions,	a conseque											
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. Box 68760	that the death certificate be ex led by the attending physician detached for use as the buria	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal	death 3] Ectopic pre] Other (speci				23d	. Date of del Month	ivery Day Year		
ls, P.O	v requires that the state of the state of the sension of the should be detailed.	ह्	Part II. Other significant condition	ons contributing to death b	ut not resul	lting in the u	nderlying cau	se given ir	Part I.				the cause of death?		
Division of Vital Records,	The lav ate has page 2	Completed								perf	s an 2 ppsy ormed? 2 No		topsy findings available completion of cause of		
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n of V	iding Physici th. After this cer funeral direct	cate: To	27. Manner of Death 1 Natural 5 Pendir 2 Accident Investi	28a. Date of inju (Month, Day	ry 2	R/Outpatien 28b. Time of injury		Injury at work?	2 \(\text{Nursing H}	ome 5 Res 28d. Describe			ify)		
Divisio	to the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	3 Suicide 6 Could 4 Homicide determ	ne, farm, stre	eet, factory, of	fice			(Street and Nu wn, State)	umber or Rui	ral Route Number,				
_	Hospital 24 hours Funeral I	Medical	(Check 2 Medical E	Physician: To the best of examiner: On the basis of examiner: To the	xamination a	and/or invest	igation, in my	opinion, de	eath occurred a	at the time, date	and place, and	d due to the d	cause(s) and manner stated.		
	To the within 2 To the comple	Σ	only one) 3 Li Certifying 29b. Signature and title of certifies		u)	Kilowiedge, C	29c. Li	cense nun	nber		29d. Date si	gned (Month			
F	ſ		30. Name and address of person	A,MD 5	401	010	rint) Cou						navyland		
	Stat Registra		31. Date filed (Month, Day, Year) NOV 2 0 2	2012 Leven	ar's Signatur	par	del					C	21133		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 11 Physician/ 16 2012 8:05 A M Ophelia Hunter-Tinsley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Upper Marlboro 11608 Rolling Glen Way If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🏻 F Months Days Hours (Month, Day, une 21 Year) Alabama 1937 **Director** June 75 416-48-8540 Usual Residence of Decedent show 10b. County 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10a. State 10c. City. Town or Location with the Maryland Director 1 XYes 2 No Upper Marlboro MD Prince George's 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20772 USA 11608 Rolling Glen Way ıral", or items 2 I Examiner mus death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i equ injury or other traumatic event, the Medical Examination Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify Black 3 ▼ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Service Representative Government 4years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Cook Lury Lizzie Barkley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10205 Spring Water Lane Upper Marlboro, MD 20772 Tandelyia Samuels/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Cemetery 11-30-2012 Hyattsville, Maryland 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. . Signature of Funer scervice Li 7474 Landover Road, Hyattsville, MD 20785 3a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Alzheimer's Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Aortic Valve Disorder Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Peripheral Vascular Disease Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month Day Year Pregnant at time of death should be detached 9 | Unknown 9 Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page 2 death? 1 ☐ Yes 2 ☐ No 1 Yes 2 N filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 힏 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred s after death. (Month, Day, Year) 1 Natural 5 Pending М 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical within 24 hou

To the Fune

completed fi 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination allows investigation, it may optimize the control of the cause (s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated. 29b. Signature and title of certifier 29d. Date sjigned (Month, Day, Year) Me 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marie Dobyn

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 0 2012

7350 Van Dusen Road #320 Laurel, MD 20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 P M Ying-Sheng 3:30 Horng November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) Director 219-27-2407 1 X M 2 D F January 15, 1957 Taiwan 55 Usual Residence of Decedent ad other then "neturel", or items 23e or 28a-f shov event, the Medical Exerciper must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Meryland Director 1 ¥ Yes 2 ☐ No Rockville <u>Maryland</u> Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 20850 312 Watkins Circle United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 Never Married 2 X Married Marylahd 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Divorced Completed Year or Dates. Asian 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

| Compared to the 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit, Page 1 and 2 should be filed within 72 l Department of Health and Mental Hyglene, importent: If item 27 is marked other then "ne eny injury or other traumatic event Elementary/Secondary (0-12) College (1-4 or 5+) Software Engineer Computers 5+Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Jue-Ming Hong Bao-Ru Gu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kai-Ti Yen / Wife 312 Watkins Circle, Rockville, Maryland 20850 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 24. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 2012 21. Signature of Funeral Service Licensee Robert and Address of Facility of Funeral Home/Rockville, Inc. Who Differ 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician liver andio far come disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner GILAVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine car dio regpirator attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. il or Attenung Physicien: The lew requires that the after death. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Atter this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 1×10 မြ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending To the Hospital or Attenuir within 24 hours efter death.

To the Funerel Lirector: Af completely filled in by the fu 1 Tes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗋 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) November 18, 2012 174374 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) DV Medical center Down Roduille, Montand 20850 Kommineni, MD 9901

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

NOV 2 U 2012

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November

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32. Registrar's Şignature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 16, 2012 Estes Houston 1:50 РМ Helen Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Carriage Hill Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Days Hours **Director** 561-34-3174 1 □ M 2 🗓 F February 12, 1915 97 Missouri Usual Residence of Decedent I Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b Count 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Tes 2 X No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 20817 6801 Hillmeade Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. ğ 1 Never Married 2 Married Yes, Give 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Nidowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Real Estate Real Estate Broker or other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Iva Cox John Elmer Estes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stuart Estes Houston/Son 4880 Chevy Chase Drive, Chevy Chase, Maryland 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 20, Montgomery Crematorium, Inc. 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Bethesda, Maryland 22. Name and Address of Facility. Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 21. Signature of Funeral Service Licensee M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration Pneumonia
Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Dysphagia Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Acute Cerebral Vascular Accident that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Dementia IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 16/2012 D35579

Registrar

State

Baltimore, Maryland 21215-0036

68760

Box

<u>Б</u>

Records,

Division of Vital

Susan J. Miller, M.D. 8218 Wisconsin Avenue, Bethesda, Maryland 20814

Back

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 2 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Marjorie G. Harmon November 11:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours (Month, Day, Year) Director 212-20-9659 1 □ M 2 🂢 F Yrs 89 Sept 30, 1923 Maryland Usual Residence of Decede 2 should be filed within 72 hours after death with the Maryland ith end Mentel Hygiene.
27 is merked other then "natural", or items 23e or 28a-f show traumatic event, the Modical Exprirer must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 🗌 Yes 2 ី No Phoenix 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 2806 Paper Mill Road 21131 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes Give 3

Widowed 4 □ Divorced Specify. Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 08 n/a Homemaker Own Home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 William Frederick Gover Amelia Mav Barrett 1 end 2 should be of Health end Mer item 27 is merk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 Department of Health Importent: If Item 27 any injury or other tr Shirley Mullendore/Daughter 19710 Old York Road, White Hall, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Poplar Grove Cemetery 11/19/2012 Phoenix, Maryland Bryan W. Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.

Timonium Marvland 21093 Timonium, Padonia Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ divergrand Neces Medical Wied. Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): ettending physician and I for use as the buriel-transit The lew requires that the deeth certificate be executed Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the end be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy certificate Yes 2 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 2 X No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be

P.0. Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, of Vital Division

State Registrar

Medical

29a. Certifier

(Check

3 🗆 29b. Signature and title of certifier

2

701 N. Charles ST HALVES 31. Date filed (Month, Day, Year) 32 Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number.

29d. Date signed (Month, Day, Year)

City or Town, State)

an Nozmat

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in mutation

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rosedale FRANKLIN SQUECESE HOSPITal If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Hours 236-46-2410 81 1 🗆 M 2 🔀 F Director January 16,1931 Usual Residence of Deced ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location Director Maryland Baltimore White Marsh 10e. Street and Number 10f, Zip Code Funeral 11628 Jerome Avenue 21162 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Examiner Armed Forces?
1 ☐ Yes 2 💆 No ori à 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar If Yes, Give 3 XWidowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Line Worker 10 years Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, phrevs George Ratliff Cora Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Humphreys son 570 Inwood Drive, Mansfield, Ohio 44903 20a. Method of Disposition 20b. Place of Disposition (Name of November 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State White Chapel Mem Grdn 4 Donation 5 Other (Specify) 23, 2012 21. Signature of Funeral Service Licenses Conneily Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician. Due to (ras a consequence o Failuse Medical resulting in death) **Examiner** P nemonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) in the past 12 months? the a 9 Unknown P.O. detach þ been signed the should be det Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. þ

Certificate of Death

Humphreys

for State Registrar

Irmil

Physician/

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2&3 Per PHY G934 12/17/2012 JH
State of Maryland / Department of Health and Mental Hygiene 37256 2. Date of Death 11/18/2012 3. Tinle: 555 ym SOMM 4c. County of Death Baltimore 9. Birthplace (State or Foreign Kentucky 10d. Inside City Limits 1 🗌 Yes 2 🔀 No 10g. Citizen of What Country? USA Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry MTD Manufactures 20c. Location - City or Town, State Barboursville, WV. Interval Between Onset and Death days 23d. Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Dav. Year)

24a. Was an autopsy performed'

26. Place of Death (Check only one)

28c. Injury at

1 Yes 2 No

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Square DR

Yes 2 No

11/9/2

Balto md

State Registrar

Division of Vital Records,

To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be

Completed

Be

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Certificate:

Medical

25. Was case referred to medical

29b. Signature and title of certifier

Sumanto

31. Date filed (Month, Day, Year) NOV 2 0 2012

2 No

5 Pending

Investigation 6 Could not be

determined

examiner?

1 \(\text{Yes} \)

27. Manner of Death

1 Natural
2 Accident
3 Suicide
4 Homicide

29a. Certifier

FRANKLIN

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

M.D.

ack

28a. Date of injury (Month, Day, Year)

SUMANTO SOM

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Som

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day NOVEMBER 15,2012 Medical WILLIAM HENRY HUETTNER JR 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SENATOR BOB HOOPER HOUSE FOREST HILL HARFORD Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday 219-32-8431 Director 1 XM 2 . F 79 JUNE 3,1933 MARYLAND Usual Residence of Decedent ir then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Director MD. HARFORD BEL AIR 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1337 SARATOGA DRIVE 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Completed by Yes 2 No Yes, Give 1 ☐ Yes 2 👿 No Specify: WHITE 3 Widowed 4 Divorced Year or Dates. 1953-1955 Maryland 21215-0 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) SUPERVISOR TELEPHONE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM HENRY HUETTNER, SR. LOUISE NIES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Department of Health en Important: If item 27 is any Injury or other traul 000.00. JOAN HUETTNER **SPOUSE** 1337 SARATOGA DRIVE BEL AIR, MD. 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) DULANEY VALLEY TIMONIUM, MD. 11-19-2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BEL AIR 610 W. MACPHAIL ROAD BEL AIR MD.21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician/ RONAR disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consiquence of: Exami es the burlal-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 74 hours after death.

Funeral Director: After this certificate has have alread his the control. IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Records, 1 Yes 2 No 3 Probably W Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No 1 🗌 Yes within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tit eted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year JOSEPH HENRY HUMMEL, JR. Vovember 9:10 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Citizens 1/2 Nurs In Grace 8. Date of Birth (Month, Day, . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 🖳 M 2 🗆 F Days Min. Director 61 217-58-7171 2/20/1950 Usual Residence of Decedent If item 27 is marked other than "natural", or items 29a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits HARFORD BEL AIR 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21014 300 SUNFLOWER DR APT 143 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other than "nature". Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) BALTIMORE CITY MACHINE OPERATOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EVELYN WOODEN JOSEPH H. HUMMEL SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State Zie Code) 2308 CASTLETON RD DARLINGTON, MD 21034 CHERI CRIZZLE-NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State OAKLAWN CEMETERY 11/21/12 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign 22. Name and Address of FacilitySCHIMUNEK FUNERAL HOME BEL AIR 610 W. MACPHAIL RD BEL AIR, MD 21014 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events. Examine ending physician and use as the burial-tran that initiated events resulting in death) Last Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Hospital or Attending Physician: The law requires that the ng to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available performed autopsy prior to completion odeath? Division of Vital 25. Was case referred o medical Be 26. Place of Death (Check only one) examiner? 2 🔼 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) er of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 \square Pending Accident 1 Tyes 2 No after death Investigation 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide etermined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sign (Month, Day, Year) Name and address of person who co eleted cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ VOV mun Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Maryland Saltimor If Under 8. Date of Birth **Funeral** If Under 24 Hrs. 9. Birthplace (State or Foreign (Month, Day, Davs Min Director 672-63-7171 MD 2 10 Sep 3, 2012 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Harford 1 X Yes 2 No MD Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21085 549 Terrapin Terrace U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 10 þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify "natural", Black Specify: Completed 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 0 Infant Infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dana Hunt Keisha Jones should I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .8 permit. Page 1 and 2 sl
Department of Health a
Important: If item 27 is
any injury or other tra Keisha Jones 549 Terrapin Terrace Joppa, MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Mt. Zion Cemetery Nov 20, 2012 Lansdowne, Maryland 4 Donation 5 Other (Specify Name and Address of Facility
 Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 21. Signatu a of Tune A Servi er the disease or complications that cau shock a heart failure. List only one cause on each Interval Between Onset and Death Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death ned by the at detached for 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an Were autopsy findings available page 2 After this certificate has autops prior to completion of cause of death? 1 L Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be 2 No Hospital ၉ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) work? 1 Natural 5 Pending injury n 24 hours after death.

Ne Funeral Director: A pletely filled in by the fi 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 0 29c. License number

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year Beverly Jane Hansen Ovember 0730 AM Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Year) Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Director 149-22-4546 1 □ M 2 🕱 F 83 07/28/1929 Usual Residence of Decedent NYms 23a or 28a-f show must be notified at 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1213 Lorene Drive 21122 U.S.A. "natural", or items edical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 21215-0036 1 Yes 2X No Specify. Completed 3 Widowed 4 Divorced Specify J Hygren. d other than "naw." *he Medical F White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Administrative Office Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 is marked Floyd Baker Gladys Hoag 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Page 1 and 2 Mrs. Karen L. Meister t of Healt : If item ? / or othe 1213 Lorene Drive, Pasadena, Maryland 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Department Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11/18/2012 | Glen Burnie, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD MOI357 Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Promician/ neumonia Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ding physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital မ Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accider
3 Suicide Accident Investigation 2 🗆 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year. MD NO073466 November 17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 06-2011

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	State of Maryland / Department of He	ealth and Mental Hygiene

	1- For State Registrar	of Maryland / Department Certificate		Reg. No	2012 3726
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last Thomas Len	Herron		2. Date of Death Month Day November 10,	3. Time of Death 2012 1152 hrs
(-	4a. Facility Name (if not institution, give 1543 Fairview Beach Road	·	4b. City, Town, or Location of Deal Pasadena		c. County of Death Anne Arundel
Funeral	5. Social Security Number 6. Se		If Under 1 Year If Under 24Hi	s. 8. Date of Birth (MM	I/DD/YYYY) 9. Birthplace (State or
Director		M 2 F 46	Yrs. Months Days Hours Mi	n. 01/22/19	P66 Foreign Country) MD
, any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
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the Marylanc inted at onc Director	8387 Carol Driv	e	10f. Zip Code 21122		tizen of What Country? United States
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiente. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other transmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispenic Origin? (\$ if Yes, specify Cuban, Mexican, Puerl		14. Race - American Indian, Black, White, etc.
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2121 ould be fi d Mental I s marked fic event,	19a. Informant's Name/Relationship (T	rpe, Print) 19b. Mai	ling Address (Street and Number or	Rural Route Number, C	City or Town, State, Zip Code)
, MD and 2 sh rath and 2 sh rannat	Mrs. Lynda J. Fish 20a Method of Disposition		2 National Highwa		Location - City or Town, State
nore ages 1 a	1 Burial 2 X Cremation 3	Removal from State crematory or	other place)		len Burnie, MD
Saltir emit. P epartme nporta:	4 Donation 5 Other Specify: 21. Signature of Funeral/Service Licen	22	2. Name and Address of Facility S	ingleton Fu	neral & Cremation
Physician		cations that caused the death. Do not ente			Clen Burnie, MD 2106
/Medical / xaminer		ch line. Contact Gunshot Wound of Head	d		Between Onset and Death
The second secon	or condition resulting in death) Sequentially list conditions, b.	Oue to (or as a consequence of):			
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f Vital Physician or this certi al directo To Be	1 Yes 2 No	ospital: 1 Inpatient 2 ER/Outpatie			ence 6 🗸 Other: Scene
Division of Vital Records, P.O. is or Attending Physician: The law requires that it is after death. "al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deacertification: To Be Completed by F	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury FOUND: Day,Year) FOUND: FOUND: 1153 bro	of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how in Subject shot self	
Division o apital or Attending hours after death. Tilled in by the func Certification:	2	28e. Place of Injury - At home, farm, si	treet, factory, office building, etc.	or Town, State)	and Number or Rural Route Number, City
D Hospital 4 hours Funeral ely fille	4 Homicide 29a. Certifier 1 Certifying Physician	(Specify) Park/Recreation Are			ch Road, Pasadena, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi-Medical Certification: To Be Completed by Physician/Medical Ex	one) 2 Medical Examiner	On the basis of examination and/or investi and manner stated.	gation, in my opinion, death occurred		
Ž	29b. Signature and title of certifier	allav	29c. License number O.C.M.E.		Date signed (Month, Day, Year) vember 11, 2012
	30. Name and eddress of person who	, - 0			,
PV State	Carol H. Allan, MD Assis	stant Medical Examiner 900 W		e, MD 21223	
Registrar	NOV 2 0 20	2 August 2.	ale		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 15. Gwenda L. Hyman 9:00 pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arden Court Assisted Living Center Potomac Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Director 132-34-0935 1 □ M 2 🗓 F 78 08/22/1934 England 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director DCWashington 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2721 P Street, NW 20007 u.s.A. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Potter Art Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred George Pearce Edith Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles O. Hyman - Husband 2721 P Street. NW. Washington, DC 20007 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or o 1 Burial 2 X Cremation 3 Removal from State Ft. 4 Donation 5 Other (Specify) Lincoln Crematory: 11/23/2012 Brentwood, Maryland 21. Signardre of Funeral Service Lice 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Stroke Medical resulting in death) Due to (or as a consequence of): Examiner Cerebrovascular Accident Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Yes 2 No To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗡 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \cancel{K} Other (Specify, Assisted Living 1 Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After I 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Certifying Nurse Practitioner: 29b. Signature and title of certifie D0064024

Registrar DHMH 17 Rev 06-2011

State

OV

M.D., 11125 Rockville Pike, #110, Rockville, Maryland 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lachtchinina,

31. Date filed (Month, Day, Year)

November 16, 2012

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#2perpHYS G939 5/7/2013 WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Day 2012 Jean B. Hawkins 2320 М Nov. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Silver Spring Bedford Court 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Davs Hours (Month, Day, Year) Director 578-24-7809 1 □ M 2 🖾 F 92 Yrs Jan. 1,1920 Nebraska Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Iem 27 is marked other than "natural", or items 23a or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Director Rockville MD Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 USA 16908 Old Colony Way 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black. White, etc δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Executive Secretary US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen Lea McCluhan Frederick McVicker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16908 Old Colony Way Rockville, MD 20853 Leah Taylor / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
eny Injury or ott 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) inal Journey Crematory 11/20/12 Woodbine, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 M01651 Reverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 6 MONTHS Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transit Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown **CVA** 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2X No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 DXNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred Livina 1 X Natural 2 Accident 5 Pending 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated at Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check niy one) 29b/ Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-19-12 D28656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rávi Passi, M.D. 15245 Shady Grove Rd. Rockville, MD 20850 31. Date filed (Month, Day, Year) 2012

DHMH 17 Rev 06-2011

State Registrar

2. Registrar's Sign Ture

Donald James H		esty 1- For State	S	ate of	Maryla	nd / Depa	artment o	f Health a	and Men			gibic.	001	2726
Physicia		Registrar 1. Decedent's Nan	ne (First, Midd	le,Last)			illicate of	Death		1:	2. Date of De	Reg. No.	.Uli	3. Time of Death
Medical Exami		4a. Facility Name	î	Donal		es Hard	lesty				Month Novembe	er 17, 2012		2052 hrs
		Laurel Reg	`		eet and nur	nber)		4b. City, Town, Laurel	, or Location o	of Death			nty of Death e George	
Funeral		5. Social Security	`	6. Sex	-	7. Age (In yrs, I	ast birthday)	If Under 1 Y	ear If Unde	er 24Hrs.	8. Date of B			thplace (State or
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Baltimore,	if of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State		natory or other plac	ce)	Date	20c. Location - City o	·		
Iltim	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	4 Donation 5 Other (Specify) 21. Signatore of Funeral Service License	*						, Maryland l Home, Inc.		
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Division of Vital To the Hospital or Attending Physician	within 24 hours affish death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical	(Check 2 Medical Examine	ng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. I Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. In Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
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	5V		30. Name and address of person who co Atul Rohatgi, M.D				, Betheso	la, Mary	land 20814			
27	Stat	e	31. Date filed (Month, Day, Year)	32. Resistrar's Sign	ature							
	Registra	1	NÓV 2 0 20	12 Jenne	1.4	all						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** oleman 16:00 AM Jenkins 2012 /Medical 4b City Town or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and no Examiner Franklinwood Birthplace (State or Foreign **Funeral** Months Min Director death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10e, Street and Number USA 21206 Ave. 14. Race - American Indian, 12. Was Decedent Eve Armed Forces? 1 Myes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Black Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Jupervisor 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be s 1 and 2 should be fil Health and Mental H tem 27 Is marked ott 19a. Informant's Name/Relationship (Type. Print) Camad 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Rumelia Circle Essex, MD 21221 Frances Jenkins-Daughter permit. Pages 1 an Department of Heall Important: If item 2 any injury or other once. injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State 11/20/2012 Dwings Mills, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brank Meller 1101 B. North Ave. Baltimore, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or de diconsequence of) Examiner The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Feta! death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 2□ No 1☐ Yes 1 TYes Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 0 Hospital: 1 Inpatient 2 ER/Outpatient 3□ D0A Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Hospital or Attending 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide 24 hours a Funeral I ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 0 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr

State Registrar Myneses

32. Registrar's

31. Date filed (Month, Day, Year) NOV 2 0 2012

sindswest Ct. Fallston, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 12, 2012 3202PM Vovember Tyrone Kevin Jackson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince George's Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days (Month, Day, Year) Hours Director 578-82-2813 1 🕅 M 2 🗆 F 35 June 12, 1977 Marvland Usual Residence of Decedent Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1X Yes 2 □ No MD Prince George's Ft. Washington 10f. Zip Code 10g. Citizen of What Country? 6900 St. Ignatius Drive 20744 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes. Give 3 Widowed 4 Divorced Specify: **Black** Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Janitor Government Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Earl Dunbar Jackson Jean Elizabeth Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Sabrina Jackson-Coates/Sister</u> 5100 Wilkins Drive, Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date XBurial 2 Cremation 3 Removal from State cemetery, crematory or other placel Donation 5 Other (Specify) Harmony Mem. Cemetery 11-24-2012 Hyattsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 7474 Landover Road Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ crhythmia disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any heading to the classic cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Country for the attending physician and for use as the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Dav Year signed by the a 1 ☐ Yes 2 ☐ Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy After this certificate 1 ☐ Yes 2 🗷 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛛 No မ 1 Inpatient 2 KER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural injury work? 1 Yes 2 No 5 Pending eral Director: / filled in by the t Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral I Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature 29d. Date signed (Month, Day, Year)

State Registrar 62822

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sutvam Vashi, MD o 8118 6000

Registrar's Signa

MDD 72075

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Irvin Frederick Jones 2012 5:10 p M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore <u> Gilchrist Hospice</u> Towson If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours Director 1 🖵 M 2 🗆 F 218-24-9120 82 Apr 17, 1930 Maryland or then "natural", or Items 23a or 28s-f shov the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Directo MD Howard Columbia 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6318 Leafy Screen 21045 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 X Married X Yes 2 ☐ No Yes, Give altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1952-60 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) al Hyglene. Elementary/Secondary (0-12) Media Technology Sales of Health and Mental Hyglifitem 27 is marked other other trsumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frances Jeanette Kountz Page 1 and 2 should be Irvin Leroy Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6318 Leafy Screen Columbia, MD 21045 Sola Jean Jones / wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Importsnt: If It is sny injury or o 1 Durial 2 Cremation 3 Removal from State Final Journey Crematory 11/19/12 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A Clarksville. MD 21029 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami uss as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ٥ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) sate has been signed by the a page 2 should be detached. g 🗌 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate it completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 □146 မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 P Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ãП only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the of cert 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar ARATHI K

NOV 2

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year NO UZAD 45cm Jackson Medical LO. V 2 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1+usn-6 Social Security Number mar or 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Days Min 213-36-5193 **Director** 1 🗆 M 2 🗷 F 74 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location notified at Director 10d. Inside City Limits 28a-f MI 1 Tyes 2 No Hmore 10e. Street and Numbe ō 10g. Citizen of What Country? iral", or items 23a o Examiner must be Funeral 21208 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural". 3 Widowed 4 Divorced 3100 Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental H 7 is marked of မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str State, Zip Code) Health tem 27 APT 201 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of I Important: If ite any injury or ot Nurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 5 Other (Specify) 4 Donation 21. Signature 1 Fineral Service Lic insee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Frymician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence oi). use as the burial-transi attending physician and Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown be detached for Day Year Pregnant at time of death the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 2 Yes 2 No 3 Probably 4 □ Unknown Completed 24a. Was an 24b. Were autopsy findings available has autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No 1 Yes the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 1 Yes 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Director: After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 029085 -1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Michael Joseph Johnson 12:30 PM 2012 Medical November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick 409 W. Patrick Street Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign Funeral 8. Date of Birth (Month, Day, Year, Country) Director 375-62-0834 1 M M 2 □ F Sept. 9,1956 Michigan 56 10b Count 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 USA 409 W. Paterick Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. ģ 1 X Never Married 2 Married If Yes Give 1 ☐ Yes 2 ☑ No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pawn Broker Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Johnson Jessica unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 W. Paterick Street Frederick, MD 21701 Jessica Thayer / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/20/12 Woodbine, MD

Priysician/ Medical

Hospital or Attending Physicien: The law requires that the death certificate be executed

24 hours after death. • Funeral Director: After this certific. letely filled in by the funeral director,

To the Hosp within 24 ho To the Fune completely f

Division of Vital Records, P.O. Box 68760

th and Mental Hygiene. 27 is marked other than "natural", or items 23e or 28a-f shov treumatic event, the Medical Examiner must be notified et.

should be filed with and Mental Hygien is marked other the

I and 2 should by the Health and Meitem 27 is mark

permit. Page 1 and 2 Depertment of Health Important: If item 27 eny Injury or other tr

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

resulting in death) **Examiner** Sequentially list conditions, if any leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-trar

F FEMALE:

Physician/Medical

þ

Completed

Be

၉

Certificate:

Medical

21. Signature of Funeral Service Licensee

Immediate Cause (Final

resulting in death) Last

23b. Was decedent pregnant

4 Homicide

Signature

in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Myocardial Ischemia Due to (or as a consequence of): Hepatocellular Carcinoma Due to for as a consequence of;

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Due to (or as a consequence of)

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death

3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death

23d. Date of delivery Month

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

autopsy pertorm

^{22. Name and Address of Facility}
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Day

Year

hours and Death

month

24a. Was an ☐ Yes 2 N 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of 1 ☐ Yes 2 🔀 No

25. Was case referred to medical examiner? 1 Tes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 X Natural 5 Pending ☐ Accident ☐ Suicide Investigation

Other: 4 \(\bigcap \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 28c. Injury at 1 Yes 2 🗌 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

6 Could not be

title of certifier

NOV

determined

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

D44164

29d. Date signed (Month, Day, Year) 11-19-12

23e. Did tobacco use contribute to the cause of death?

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A.Zakaria Hegazi, M.D. 46B Thomas Johnson Dr. Suite 200 Frederick, MD 21702 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

12-08484 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Cordell Jackson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death **Medical Examiner** November 8, 2012 2318 hrs Cordell Jackson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital **Baltimore** 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Days Foreign Country) Months Hours Min 1 M 2 XF 219-62-4417 55 31 /1956 MD Usual Residence of Decedent in y 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1XXXYes 2 ∭ No with the Maryland Director N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3800 Belvedere Avenue 21215 USA items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black hours after death Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. 9 Yes 2**X**XNo 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2X No specify: Specify: Black <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) mit. Pages 1 and 2 should be filed within 72 l partment of Health and Mental Hygiene. portant: If item 27 is marked other than "! ury or other traumatic event, the Medical E College (1-4 or 5+) Baltimore, MD 21215-0036 Bus Driver MTA 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Robert Jones Shirley Jones ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Jones Denison Street, Baltimore, Md. 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department Important: Donation 5 Other Specify Memorial Park 11/17/2012 Windsor Mill, MD. permit. 21. Signatur Funeral Service License 22 Name and Address of Facility Estep Brothers Funeral Service, BAltimore, MD., 1300Eutaw Place 23a. Part . Enter the disease, or complications that haused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line /Medical Between Onset and Cocaine Intoxication Immediate Cause (Final disease Death Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed ned by the attending physician and detached for use as the burial - trans Sa X UNPENDED AMENDED 23a, 27, 28a-f, per me, g933 11-28-12 sm Physician/Medi Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 . Fetal death 3 Ectopic pregnancy past 12 months? Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown 9 Unknown signed by the bedeached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed After this certificate has been s funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural e Funeral Director: A ctely filled in by the fu Pending 1 Yes 2 No unknown fd 11-8-12 fd 10:00 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number, City or Town, State 3800 West Belvedere Ave. Baltimore, MD. 3 6 X Could not be Suicide determined (Specify) found at home Homicide 29a. Certifier (Check only one)

29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my onlying, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Sa within 2 ţ 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME ORIG

Assistant Medical Examiner

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD

31. Date filed (Month, Day, Year)

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

November 9, 2012

JACKSON, SHEILA A Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	State Registrar Decedent's Name (First, Middle, Last)	Certificate of Deatl		Reg. No. ZUI	2 3727					
an/ cal	Sheila A. Jackson		2. Date of I Month	Death Day Ye	3. Time of Death					
ner	4a. Facility Name (if not institution, give street and number) Good Samaritan Hospital	4b. City, Town, or Location Baltimore	on of Death	4c. County of D	Death					
	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under	der 24 Hrs. 8. Date of E s Min. (Month, I Jan	Birth 9.	Birthplace (State or Fore Country)					
tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town MD N/A Balti			,	10d. Inside City Limi					
al Director	10e. Street and Number 4218 Ivanhoe Avenue	10f. Zip Code		10g. Citizen of What	1 Yes 2 🗆					
Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	21212	Origin? (Specify Yes or No	USA 14. Race - A	merican Indian,					
þ	1 ☐ Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexion 1 Tyes 2 Honor Spec			hite etc					
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Decedent's Usual Occupation 'Give kind of work done during m ife. DO NOT use retired)	ost of working	16b. Kind of Busine	ess/Industry					
Be Co	9th N/A HOT	usekeeper		Hotel						
2	Russell Vaughn		llie Morga							
	19a. Informant's Name/Relationship (Type, Print) Helen Allen/Sister 19b. 45	Mailing Address (Street and Nun 504 Garrison	nber or Rural Route Numb Blvd Balt	per, City or Town, State,	Zip Code) 21215					
	1 Burial 2 Tremation 3 Removal from State cemetery	Disposition (Name of crematory or other place)	Date	20c. Location - City						
	4 Donation 5 Other (Specify) 21. Signature of Signature	Crematory 22. Name and Address of Fac 2700 Edmond	11/19/12 Beverly		ille, MD					
	23a. Part . Enter the disease, or complications that caused the death. Do no				D 21223 Approximate					
	Immediate Cause (Final disease or condition Final Stage No. 2012)	WS **	, ,		Interval Between Onset and Death					
	resulting in death) Due to (or as a or sequence of):									
xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
ш	that initiated events c									
ledica	a Congulopathy									
Physician/Medical	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	23d. Date of Month	23d. Date of delivery Month Day Year							
by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Pa	200. 510	tobacco use contribute						
Completed	Renal failure		24a. Wa		autopsy findings availal					
Com			per	formed? death	to completion of cause 1? Yes 2 No					
To Be	25. Was case referred to medical examiner? 1 Yes No Hospital: Inpatient 2 ER/Outp	Other:	eath (Check only one) Nursing Home 5 Res	sidence 6 Other (Sr	ancifu)					
	27. Manner of Death Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) inj	ne of 28c. Injury at work?	28d. Describe	how injury occurred	ossiny					
l Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)		28f. Location	(Street and Number or , wn, State)	Rural Route Number,					
Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de conly one) 3 Certifying Nurse Practitioner: To the best of my knowledge, de conly one) 1 Certifying Nurse Practitioner: To the best of my knowledge, de conly one) 1 Certifying Nurse Practitioner: To the best of my knowledge, de conly one) 1 Certifying Nurse Practitioner: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best	investigation, in my opinion, death	occurred at the time, date	and place, and due to the	ne cause(s) and manner s					
	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	nth, Day, Year)					
			11/15/2012							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 11:34 PM November 2012 Blaine Kauffman Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Pasadena 8028 Forest Glen Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 29 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 218-18-7303 1924 87 Director 1 XM 2 □ F Yrs 10d. Inside City Limits 28a-f show 10c. City, Town or Location Page 1 end 2 should be filed within 72 hours after death with the Maryland ment of Heelth and Mental Hygiene.

ent. If item 27 is marked other than "natural", or Items 23a or 28a-f shoury or other treumetic event, the Medical Example or must be notified at 10a. State 10b. County by Funeral Director 1 Yes 2 V No MD Anne Arundel

10e. Street and Number Pasadena 10g. Citizen of What Country? 10f. Zip Code 8028 Forest Glen Drive

12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes : 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Plumbing/Union 486 Plumber 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Julia Johnson Kauffman Scott Winfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8028 Forest Glen Drive, Pasadena, MD 21122
of Disposition (Name of Date 20c. Location - City or Town, State John Kauffman/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 e
Department of I
Importent: If ite
eny Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Motro Crematory 22. Name and dress of Facility 11/17/2012 Baltimore, MD 21. Signature of Funeral Service Light Stallings Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the clear. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Course (First) Interval Between Onset and Death Immediate Cause (Final CONGESTIVE HEART FAILURE Physician disease or condition resulting in death) Medical Examiner CARDIOMYOPATH ISCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and CORONARY ARTERY attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown A SBESTOSIS HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 2 No SICK SINUS SYNDROME deatn? 1 ☐ Yes 2 💆 No within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be iner? Other: 1 Yes 2 X No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27 Manner of Durth Certificate: 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig

DHMH 17 Rev 06-2011

State Registrar mantelus

MARK KIM, MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1412N. CRAIN MWY GA

Registrar's Signature

D54574

GLEN BURNIE

16/12

MD 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Novembe Physician/ Day 1947 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AA Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Days Months 1 M 2 N Hours (Month, Day, Country) 219-16-142 Director Usual Residence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MA tanover 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 21076 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes Give 3 Nidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) tomema Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ္ annie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) navon 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Service Licenses 22. Name and Address of Facility Funera 20794 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physiciani men disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause (Disease or linjury Due to (or as a consequence of): burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 40 3 Probably 4 Unknown 1 Yes After this certificate has been Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Yes the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital. 2 46 Other: 2 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After injury 1 Natural 5 Pending 2 \square No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier death (Item 23a) (Type, Print) person who/completed cause of

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ Kenneth Knight AM Raymond ovember 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 212-32-5668 77 Director 1 📉 M 2 🗆 F March 18 1835 MD Usual Residence of Deced or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 Yes 2 XNo Maryland Anne Arundel Pasadena 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 3491 Marble Arch Drive 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examinone. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 X Married 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Store Manager Acme Super Market 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Milton Clark L. Knight Catherine V. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3491 Marble Arch Drive, Pasadena, MD 21122 Janet S. Knight (spouse) 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State Nov. Date 21 1 X Burial 2 Cremation 3 Removal from State Glen Haven Cemetery Glen Burnie, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig of Funer 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 ns the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. 23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one Onset and Death Immediate Cause (Final Metastatic Physician/ ancreatic disease or condition Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Due to (unde a consequence of) If any leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Pregnant at time of death been signed by the a 1 Yes 2 U Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pace 2 s autopsy performed certificate Yes 2 No 25. Was case referred to medical B 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No 은 1 🕏 Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? eral Director: After filled in by the funer 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00073466 November 18 2012

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital drive Glenburnie MD GOBERT 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Eduardo Luis Kenny 11:35 A M November 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery <u>5225 Pooks Hill Road #822 S</u> Bethesda Social Security Number If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) Director 577-96-1<u>661</u> 1 ☑ M 2 🗀 F June 24, 1925 Argentina Usual Residence of Deceden ed other then "natural", or items 23a or 28e-f show event, the Modical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location Direct 1 ☐ Yes 2 🖾 No Bethesda <u>Maryland</u> Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5225 Pooks Hill Road #822 S 20814 United States 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give "naturai", or 1 Never Married 2 X Married within 72 hours efter 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: leted 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Comp end 2 should be filed within 72 Health and Mental Hygiene. em 27 is marked other then " Argentine Naval Commission College (1-4 or 5+) Elementary/Secondary (0-12) Buyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Jane O'Farrel Tomas Kenny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5225 Pooks Hill Road #822 S. Bethesda, Mary and 20814 Vilna Bonilla-Kenny / Wife Injury or other tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pege 1 Depertment of I Important: If it eny Injury or of 1 Burial 2 X Cremation 3 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium Inc. Nov. 20, 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Betheda—Chevy Chase Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01662 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami or Attending Physicien: The law requires that the death certificate be executed physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending | for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day 5 Other (specify) Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 🖾 Residence 6 Cher (Specify) ည 1 🗌 Yes 2 🖾 No 1 Inpatient 2 ER/Outpatient 3 DOA hours efter death. nerei Director: After this y filled in by the funeral dii this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 No ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospitel c within 24 hours of To the Funerel D completely filled i Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) November 19, 2012 D59013 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Konstantin A. Khludenev, M.D. 15825 Shady Grove Road, Rockville, Maryland 20850

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 0 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Month Physician/ Sandrath Kay Karasinski 4.25AM Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** Town, or Location of Death AGNES BALTIMORE HOS PI N/A If Under 1 Year I If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) 214 40 1238 1 🗆 M 2 🏝 F **Director** 67 10/28/1945 West Virginia Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1811 Casadel Avenue 21230 U.S.A. should be filed within 72 hours after death vand Mental Hygiene.
is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: White Completed 3 X Widowed 4 Divorced Year or Dates Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Bookkeeper Manufacturing Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or cate. 2 Harry David Miller Dorothy Shade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bridget Karasinski / Daughter 3014 Illinois Avenue Baltimore, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 11/20/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Signature of Funeral Servi 22. Name and Address of Facility Gonce Funeral Service, P.A. TOMO 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical e to (or as a con equence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death 1 Lyes 2 g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an ate has I autop performed 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita A No Other: 1 🗌 Yes ဂ္ဂ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours.

To the Funeral Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier MD. who completed cause of death (Item 23a) (Type, Print) ACI 821-N-Eutew ST-Baltime MD 21201

Registrar

DHMH 17 Rev 06-201

State

31. Date filed (Month, Day, Year)

SANDRA

ASIN

32. Registrar's Signature

amend #5,15tate of Maryland Department of Health and Mental Hygiene State ammend items 1 per doc, 19a-20c, 22 per fb g934 12-21-12 vt Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 30 Evelyn Crace Kiddon October 11:45 РМ Grace Evelyn Kiddon Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sururban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 111 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours 578-28-5719 Country) unk Director 1 🗆 M 2 💢 F 86 Usual Residence of Decedent ahow 10a State 10b. County ir than "natural", or itams 23a or 28e-f aho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Chevy Chase 1 🗆 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? <1000 - 10/30/12 SOB - 10/30/12 Funeral 6008 Sonama Rd. 20817 USA 11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces? unk
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry should ba filad within 72 h h end Mantei Hyglena. 7 Is marked other than "r (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Thrift Store unk unk parmit, Paga 1 and 2 should ba filad w Dapertment of Haalth end Mantei Hygl Important: If Item 27 is marked other any Injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) Personal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randall_eT e Skaar-8923 Bradmore Dr; 3260 Carriage Dr., Bethesda. Rep/ Medina, Minnesota 55340 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗋 Donation 5 🛣 OtherySpecifyiin State cemetery, crematory or other place Lincoln Crematory 12-20-12
22, Name and Address of Facility State A Brentwood . Md Bonnid S Wate Director 22 Name and Address of Facility State and State Director Rinaldi. Fl 1800 New Silver Spring, Md. 20904

Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21. Signature of Funeral Scale e Licensee 11800_BNew Hampshire Aver Approximate Interval Between Immediate Cause (Final Onset and Death years Physician/ disease or condition resulting in death) pulmonary fibrosis Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attanding physician and I for usa as tha burlai-transi The law requires that the deeth cartificate be executed Cause (Disease or injuly that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Day ata has baan signed by tha e pega 2 should be datachad 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? cartificata 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No To the Hospitel or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certific complately filled in by the funeral director, Vita 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 🗌 Yes 2 🔯 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 10731 W MMTYY89 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sururban Hospital Bethesda, Maryland 31. Date filed (Month, Day, Year) -State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER 16, KENDRICK GERTRUDE 2012 11:10 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FOREST HILL HARFORD FOREST HILL HEALTH & REHAB CENTER If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Country 212-42-8904 Director 1 M 2 X F 92 Nov. 01, 1920 Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director notified 1 🗌 Yes 2 💢 No Maryland Harford Forest Hill 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a U.S.A. 802 Bear Creek Ct. 21050 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ural", or iten 11. Marital Status 14. Race - American Indian, Black White etc þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 ₩ Widowed 4 □ Divorced White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Envincemental Services Housing 6 Ith and Mental Hygie 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Strother Jackson Marlow Annie May Lauman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Virginia Lee Hauz (Daughter) 802 Bear Creek Ct. Forest Hill, Maryland 21050 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth cemetery, crematory or other place)
Evans Funeral Chapel &
Cremation Svos. Bel Air 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State November 20, 4 Donation 5 Other (Specify) Forest Hill, Maryland icensee Jeffrey R. Testerman 22. Name and Address of Facility Revans Funeral Chapel & Cremation Services - Bel Air Signature of Funeral Service once. (MC1543) 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1 Enve the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicians end Trage de disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 687604 the as IF FEMALE ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Second at time of death 5 Other (specify) use 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?
1 Yes 2 No Month Year 1 Yes 2 D the detached 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No • Hospital or Attending Physician: The 1 24 hours after death. • Funeral Director; After this certificate h 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No ျ 1 Yes 1 Inpatient 2 Inpatient 3 Inpatient 2 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending 1 Yes 2 No Accident М Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifie 1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Would 16. 33 2294

Registrar

State

21014

BEL AIR, MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID DUNN

31. Date filed (Month, Day, Year)

2012

615 W. MACPHAIL ROAD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER 7.26 A M <u>Leroy Daniel</u> Kehr Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death County of Death 10W SON 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) April 20, 1928 161-20-2297 Director 84 1**XX**M 2 🗆 F Pennsylvania or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at within 72 hours efter death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Timonium 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States
of America Funeral 21093 403 Plumbridge Court #102 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces?

1 Yes 2XXNo
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 white 1 ☐ Yes XXX No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Master Electrician Industrial e 1 end 2 should be filed wir of Health and Mental Hygie If item 27 is marked other ir other traumatic event, # Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame)
 Annie Stauffer ည George C. Kehr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 Plumbridge Court #102 Timonium, MD 21093 Mrs. Betty Jean Kehr/ wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of November 20c. Location - City or Town, State 5 XXBurial 2 Cremation 3 Removal from State ö St. John's Lutheran permit. Page Department (Important: It any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Columbia, Maryland Cemetery 19, 2012 21. Signature Funer I Servic Licet 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 Part 1. Enter the disease, or co shock, or heart failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1

Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X N Director: After this certificate 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Unpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Work:
1 ☐ Yes 2 ☐ No the ☐ Accident Investigation 3 Suicide 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or to the Funeral Direct completely filled in by determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner stated. of an the films, date and place; and due to the cause(s) and mainer as stated 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 32 Registrar's Signatur

DHMH 17 Rev 06-2011

Registrar

NOV 2 0 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Louise L. Kirby 2012 November 11:01P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death D Cross Keys Road Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthdav Birthplace (State or Foreign Country) 8 Date of Birth Days Hours (Month, Day, Year) 214-01-5950 98 Director 1 □ M 2**X**XF Yrs August 24, 1914 Baltimore, Maryland sual Residence of Deceden thereth and Martel Hygiene.

Them 27 is marked other then "neturel", or items 23s or 28s-f show other treumatic event, it is Medical Examiner must be notified at 10a. State 10b. County within 72 hours efter death with the Meryland 10c. City. Town or Location 10d. Inside City Limits Directo Maryland Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 2 D Cross Keys Road 21210 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. <u>\$</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3X Widowed 4 ☐ Divorced Completed Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Program Analyst Federal Government Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည William D. Ligon Anne de la Tour ige 1 end 2 should but of Heelth end Mer it of Heelth end Mer it: If Item 27 Ie mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally L. Nalley (Daughter) 1414 Crescent Spot Lane Frederick, Maryland 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pege 1 November 21, Department of Importent: If II eny Injury or o 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Spring Hill Cemetery Easton, Maryland 21. Signature of Fluneral Service Licensee

22. Name and Address of Facility
Evans Funeral Chapel & Cremation
8800 Harford Road Parkville, Me
23a. Part 1. Enterine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville
8800 Harford Road Parkville, Maryland 21234 Approximate Interval Between Onset and Death Physician disease or condition resulting in death) mal Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami or Attending Physicien: The lew requires that the deeth certificate be executed ettending physicien end d for use es the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2XXNo 4 Pregnant at time of death Year Day cete hes been signed by the opege 2 should be deteched 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

1 Yes 2 No To the Hospital or Attending Physicien: The within 24 hours after death.

To the Funerel Director: After this certificate i completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical B 26. Place of Death (Check only one) 1 ☐ Yes 21 No <u>|</u>2 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident 1 ☐ Yes 2 ☐ No Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature/and title of certifie 29c. License number 000591

State Registrar 2005

Gra

no 21224

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James Aloysius Keifer 11:40 p M Medical Novembe: 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u> Upper Chesapeake Medical Center</u> Bel Air Harford Funeral Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours Min (Month, Day, Year) 159-34-1746 Director 1 🛛 M 2 🗆 F Yrs. July 18, 1941 71 Pennsylvania 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Joppatowne 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d Mental Hygiene. marked other than "netural", or items 23e Funerai 125 Doncaster Road 21085 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married X Yes 2 No 1 Yes 2 XNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Maritime Shipping Elementary/Secondary (0-12) College (1-4 or 5+) and Receiving Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfonse William Keifer Anna (nmn) McDevitt Health and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 end 2 Lilli Ann Keifer / Wife 125 Doncaster Road, Joppatowne, MD 21085 Itam 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it eny injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Rose Hill Svcs., LLC 4 Donation 5 Other (Specify) 11-26-12 Bel Air, Maryland 21. Signature Funeral Service License 22 Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ GRAM disease or condition resulting in death) Na Medical Du to (or as a consequence Examiner Sequentially list conditions. Examine d any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The lew requires that the deeth certificete be execute within 24 hours after death.

To the Funeral Director: After this certificete has been signed by the attending physicien end completely filled in by the funeral director, pege 2 should be detached for use es the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death 9 Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 WHO 1 Yes 2 DAG Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မှ 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Upper State

DHMH 17 Rev 06-2011

Registrar

November 14.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ THOMAS JOSEPH KELLY NOVEMBER 14,2012 Medical 7:00 P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE TOWSON BALTO. If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. (Month, Day, Year) Director 212-30-3101 1 😿 M 2 🗆 F 87 5-20-1925 MARYLAND r then "natural", or items 23e or 28a-f show the Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1649 HEATHFIELD ROAD 21239 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black White etc. 1 Never Mamed 2 Married Š Maryland 21215-0036 1 Yes 2 XNo Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 DRUG INSPECTOR STATE OF MARYLAND Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of ည JOHN L. KELLY RUTH COSTELLO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Depertment of Health ar
Importent: If item 27 is
eny injury or other trau DOLORES KELLY SPOUSE 1649 HEATHFIELD ROAD BALTIMORE, MD. 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) JOHNS LONGREEN 11-21-2012 HYDES. MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. Taracia 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition CCV year Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) The law requires that the death certificete be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien for use es the burla Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, Completed 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy
performed?

1 Yes 2 No this certificate 1 ☐ Yes 2 No or Attending Physicien: director, æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No |요 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospitel or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 💆 Natural 5 Pending 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 15 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARVES W TRUSON worls 32. Registrar's signatu State Registrar

Charles Derrick Kus	1- For State Registrar Certific	ent of Health and Mental Hygien eate of Death	Reg. No. 2012 3720
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)	Mont	of Death th Day Year 2147 hrs
	Charles Derrick Kuska 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	ember 12, 2012 2147 hrs 4c. County of Death
	422 Lambeth Road	Catonsville	Baltimore County
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last bir 215-17-4735 1 M 2 F 29 Usual Residence of Decedent	Months Days Hours Min.	te of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Maryland
any	10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
or 28a-f show fied at once.		nsville	1 Yes 2 X No
the Maryland a or 28a-f sh tiffed at once	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
ith the solid	422 Lambeth Road 11. Marital Status 12. Was Decedent Ever in U.S.	21228 13. Was Decedent of Hispanic Origin? (Specify Ye	U.S.A. es or No- 14. Race - American Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "matural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Furneral Director	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	If Yes 2 \times No specify:	white, etc. Specify: White
hours a	15. Decedent's Education (Specify only highest grade completed) 16a.	Decedent's Usual Occupation (Give kind of work don during most of working life. DO NOT use retired)	
5-0036 ed within 72 hour bygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		Handlah Com
d with be Me Me	2 17. Father's Name (First, Middle, Last)	Registered Nurse 18.Mother's Name (First, N	Health Care Middle, Maiden Surname)
MD 21215-0036 3 should be filed within 7 th and Mental Hygiene. a 77 is marked other than numatic event, the Medica. To Be Complé	Frank James Kuska	Linda Lee	e Reusing
D 21 should and Me is ma aftic ev		b. Mailing Address (Street and Number or Rural Ro	
and 2 sealth a		38652 Thomas Court, Avenu of Disposition (Name of cemetery, Date	ue , MD 20609
lore ges la tt of H tt frie	1 Burial 2 Cremation 3 Removal from State crema	tory or other place)	
Baltimore, peest lan bernit, Pages lan bepartment of Hea Important: If itel important: If itel injury or other tr	4 X Donation 5 Other Specify: Anaton 21. Signature of Funeral Service Licensee		2012 Hanover, Maryland
Ba Perm Inju		Alla	tomy Gifts Registry te. P. Hanover. MD 21076
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do n failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac or respira	tory arrest, shock, or heart Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease a Hypertensive Cardiovascula	ır Disease	Death
	or condition resulting in death) Due to (or as a consequence of):		157
Jer Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	i"-	
ied nsit Examiner	(Disease or injury that initiated events resulting in death): ast		
uted nd ransit	events resulting in death) Last Due to (or as a consequence of): d.		
60, ate be execut hysician and e bunal - tra	UNPENDED AMENDED		
D.O. Box 68760, that the death certificate be executed ned by the artending physician and detached for use as the burial - transit by Physician/Medical Exby Physician/Medical Exby	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of delivery
K 68 1 certif ending use as	past 12 months? 4 Pregnant at time of death	2 Fetal death 3 Ectopic pregnancy 5 Other (Specify)	Month Day Year
b. Box 687(the death certification by the attending placed for use as the Physician/A	1 Yes 2 No 9 Unknown 9 Unknown	- Cities (Specially	
P.O. s that the greed by detach	Part II. Other significant conditions contributing to death but not resulting		e. Did tobacco use contribute to the cause of death?
duires quires en sign uld be			Yes 2 No 3 Probably 4 ✔ Unknown a. Was an 24b. Were autopsy findings available
Records, The law requires ficate has been sign, page 2 should be Completed	· · · · · · · · · · · · · · · · · · ·		autopsy performed?
tal Rection: The certificate ector, page	OE Massacrafamed to medical		Yes 2 No 1 Yes 2 No
/ital	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/C	26.Place of Death (Check only one Dutpatient 3 DOA Other Nursing Home	
of Vi	27. Manner of Death 28a. Date of Injury 28b.		escribe how injury occurred
ion itendin teath. tor: A the fu	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transiledical Certification: To Be Completed by Physician/Medical Ei	3 Suicide 6 Could not be determined (Specify)		cation (Street and Number or Rural Route Number, City Town, State)
To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de one) 2 Medical Examiner:On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the time	e, date and place, and due to the cause(s)
> ×	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year)
	30_Name and address of person who completed cause of death (Item 23a)	O.O.IVI.L.	November 13, 2012
) W. Baltimore Street, Baltimore, MD 212	223
State			
Registrar		<u>KI</u>	
DHMH 17 Rev 1/2001 OCME 2006	OGME	RIGINAL	

DHMH 17 Rev 1/2001 OCME 2006

OCME

			For State	State of M	laryland / De			and Me	ental Hyg	giene	210	07000
			Registrar 1. Decedent's Name (First, Middle,)	(cot)	С	ertificate of l	Death		Reg. No. 2012 31200			
	Physicia		1. Decedent's Name (First, Middle, I		505.				2. Date of Dear Month NOV	Day	Year	3. Time of Death
-	Medic Examir		4a. Facility Name (if not institution, g	ive street and number)		4b. City, Town, o	r Location of		14 04	4c. Cour	2012 nty of Death	11,.55
			UNIVERSITY OF M			01101	IMOR					
	Funeral Director		5. Social Security Number N/A	5. Sex 7. Aq 1	ge (In yrs. last birthda) ()	/) If Under 1 Year Months Days	If Under 2 Hours	Mig. 8	B. Date of Birth (Month) Pay		9. Birth	place (State or Foreign Taryland
	*		Usual Residence of Decedent	1 L M 2 L F	yrs.							
	Maryland 28a-f show otified at	cto	10a. State 10b. County	N1/A	10c. City, Town or	Location	37/4				1	0d. Inside City Limits
	r 28a notifi	Director	N/A	N/A		10f. Zip Code	N/A			10 0'#'	610//	1 Yes 2 □ No
	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral	N/A			Tot. Zip Code				10g. Citizen o	USA	-
	death items ier mu	Fun	11. Marital Status	12. Was Decedent	Ever in U.S. 1	3. Was Decedent of H If Yes, specify Cuba	lispanic Origi	in? (Specify	y Yes or No-		ace - Americ	
98	after (d by	1 Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No No	1 Ves 2 No		, dorto i ilo	Diack, Will			etc. dian
21215-0036	hours natura lical E	Completed	15. Decedent			cedent's Usual Occup				Business/Inc		
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121	dygier Hygier ther t	Be C	N/A 17. Father's Name (First, Middle, La.			N	I/A				N/A	
lano	be file ental ked o ic eve	2	Tr. Father's Name (First, Wilduie, Las	Niladri Kansa	ri		18. Mother	r's Name (F	irst, Middle, N Avantik	a Chakra	,	
Maryland	2 should be filed th and Mental Hy 27 is marked oth traumatic event	8	19a. Informant's Name/Relationship		19b. Ma	uiling Address (Street	and Number	or Rural R				Code)
	and 2 s Health em 27 ther tra		Niladri Kansari / Fathe	er ———————		91 Tower Side	Drive, A	Apt. 323	3, Fairfax	x, VA 220	031	
Baltimore,	ge 1 a nt of H :: If ite		20a. Method of Disposition 1 D Burial 2 Cremation 3	Removal from State	cemetery, c	position (Name of rematory or other place		Date			n - City or To	
altin	10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10d. City 1									Beltsville	, MD	
Ä	permit. Departr Importa any inji	ij	Dorota Marshall	Dente	r-leaste	Maryland Cro			es, PO Bo	x 1413 E	Baltimore	e, MD 21203
П		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
des	Immediate Cause (Final disease or condition EXTREME DREMATURITY										Interval Between Onset and Death	
7	Medical Examiner		resulting in death)	Due to (or as	a consequence of):	FAILL	DE					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence ot):	111100	100					
	outed nd transit	kami	Cause (Disease or injury that initiated events	C								
_	ate be executed physician and the burial-transit	dical Examiner	resulting in death) Last	Due to (or as	a consequence of):							
292	death certificate be executed re attending physician and ed for use as the burial-transi	ledic		d								
x 687	is that the death certific. igned by the attending p be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnance	°V			23d. [Date of delive	ery
Вох	death the att hed fo	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant : 9 Unknown		Other (specify)	- J			1	Month	Day Year
P.O.	that the ned by tl e detach		Part II. Other significant conditions	s contributing to death I	out not resulting in the	underlying cause gi	ven in Part I.		23e. Did tob	oacco use co	ntribute to th	ne cause of death?
	uires ti n signe uld be	ed by							1 🗆 Ye	es 2 X No	3 Prob	pably 4 🗌 Unknown
oro	The law requires ate has been sign page 2 should be	plete							24a. Was a			osy findings available mpletion of cause of
Division of Vital Records,	sician: The law rs certificate has b	Completed							autops perform 1 \(\sum \) Yes		death?	2 X No
ita	ysician: s certific director,	Be	25. Was case referred to medical examiner?	Hospital:	2.	Louis	ace of Death	(Check on	nly one)		wall to	
of V	al calca	e: To	1 🗌 Yes 2 🕱 No 27. Manner of Death	1 X Inpat 28a. Date of inju	ient 2 ER/Outpat ury 28b. Time	ient 3 🗆 DOA	4 L Nurs		5 Reside)
ouo	ending eath. rr. Afte he fun	icat	1 X Natural 5 ☐ Pending 2 ☐ Accident ☐ Investiga		y, Year) injury	work	Yes 2 🗆 N	- 1		ii iijai y oooc		
visi	or Atte fter de irecto in by ti	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		ury - At home, farm, s	street, factory, office		28f	f. Location (St. City or Town		ber or Rural	Route Number,
۵	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,		29a, Certifier 1 X Certifying P	hysician: To the best of	mu knowledge doet	h approved at the time	o data and s	alana and a		,		
	ie Hos n 24 h ie Fun oletely	Medical	(Check 2 L Medical Exa	miner: On the basis of e urse Practitioner: To the	examination and/or inv	estigation, in my opinio	on, death occ	curred at the	e time, date an	d place, and o	due to the cau	use(s) and manner stated.
	To the within comp		29b. Signature and title of certifier	`	2 12 0	29c. License	e number		2	9d. Date sign		
	In		- comeni	1 1	IB RZ		7200	93	1	NOV,	15,	2017
	10		30. Name and address of person wh		leath (Item 23a) (Type SOUTH GR		RECT	DΔ	H TIMB	OF N	17 7	12.01
	Stat	e	31. Date filed (Month, Day, Year)		ar's Signature	20.40 31	1001	, סח	1017101	CC, 17	1.11	
	Registra		NOV 2 0 2012	Burne	A back							

		For	State of I	Maryland					Mental Hy	giene	62 1 EX		
		1 - State Registrar			Cer	tificate o	f Death			Reg. No 2	37281		
Physic	ian/	1. Decedent's Name (First, Middle,	1	-					Date of Dea Month	ath Day	Year	3. Time of Death	
Med		4a. Facility Name (if not institution,	Canso						Nov	14	2012	19:05 M	
Exam	iner 	UNIVERSITY OF	MARYLAN.	D MEDICA		4b. City, Town	TIMUZ			4c. Cou	inty of Death	1	
Funera Directo	_	5. Social Security Number N/A	5. Sex 7 1 □ M 2 □ F	Age (In yrs. last	birthday) Yrs.	If Under 1 Ye Months Day		24 Hrs.	8. Date of Birt		9. Birth Con	nplace (State or Foreign Maryland	
nd how at	۲	Usual Residence of Decedent 10a. State 10b. County		10c. City. T	Town or Loc	eation						10d. Inside City Limits	
Maryla 28a-f s otified	recto	N/A	N/A	,,			N/A	4				Yes 2 No	
Ind 21215-0036 Filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number N/A				10f. Zip Cod	e			10g. Citizen	of What Cou		
death r items iner mu	/ Fun	11. Marital Status	12. Was Deceder Armed Force d 1 ☐ Yes 2	nt Ever in U.S. s?	13. V	Vas Decedent o Yes, specify Cu	f Hispanic O	rigin? (Spe	ecify Yes or No- Rican, etc.)		Race - Ameri	ican Indian,	
21215-0036 within 72 hours after giene. er than "natural", o	ed by	1 Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dates		1	☐ Yes 🐰	No Specify	<i>/</i> :		Spec		dian	
2 hou	bet	15. Decedent (Specify only highes		1		ent's Usual Occ		st of work	ina	16b. Kind o	6b. Kind of Business/Industry		
2121 within 7 giene. er than	Completed	Elementary/Secondary (0-12) N/A	College (1-4 c	or 5+)		NOT use retire					N/A		
Maryland 2 should be filed v Ith and Mental Hyg 27 is marked othe	To Be	17. Father's Name (First, Middle, La	•				18. Moti	ner's Nam	e (First, Middle,				
farylan should be fil and Mental is marked of raumatic eve		19a. Informant's Name/Relationship	Niladri Kansa							a Chakra			
		Niladri Kansari / Fathe			9291	Tower Sid			23, Fairfax			Code)	
Baltimore, bermit. Page 1 and Department of Hea mportant. If item any injury or other once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp	Removal from Sta	te cem	etery, crem	sition (Name of latory or other p se Cremato			Date 0/2012		on - City or To Beltsville		
Baltimo permit. Page Department Important: It any injury or once.		21. Signature of Funeral Service Lic	ensee	Lucusho	22	Name and Add	ress of Facil	*	ans PO Po			e, MD 21203	
		23a. Part 1. Enter the disease, or c shock, or heart failure. List on	omplications that caus	ed the death. D							Saitimore	Approximate	
Prysician Medica		Immediate Cause (Final disease or condition resulting in death)	a. EXT	EME	PRE	MATU	RITY					Interval Between Onset and Death	
Examine	_		0000	is a consequence	ce of):	FAIL	IRF						
sit d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	s a consequenc	ce ot):	7 / (()							
executed an and irial-trans	Exar	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a consequenc	ce of):								
BOX 68 / 60 death certificate be eatending physicial ed for use as the bur	dical		d	·									
68/ Sertifica Iding p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy	,						D. 1. 1. 1.		
DIVISION OF VITAI RECORDS, P.O. BOX 68/60 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknowr	2 Fetal de t at time of deat	eath 3 th 5	Ectopic pregna Other (specify)	ncy		_		Date of deliv Month	Day Year	
that the	by Ph	Part II. Other significant conditions	s contributing to death	but not resultir	ng in the un	derlying cause	given in Part	1.	23e. Did to	bacco use co	ontribute to the	he cause of death?	
rdS, equires een sig									1 🗆 Y	es 2 💢 No	3 Pro	bably 4 🗌 Unknown	
DIVISION OF VITAL RECORDS, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Completed								24a. Was a autop: perfor 1 \(\sum \) Yes	sy med?	 b. Were auto prior to co death? 1 \(\sum \) Yes 	ppsy findings available empletion of cause of	
cian: cian: ertifica	Be	25. Was case referred to medical examiner?	Hospital:				Place of Dea	ath (Check		Z AN INO	i 🗆 tes	2 2 NO	
Physi Physi this c	<u>اد</u>	1 Yes 2 X No 27. Manner of Death	1 X Inpa	atient 2 ER/	Outpatient	3 🗆 DOA			me 5 Reside)	
on C ath. :: After e fune	cate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investiga	(Month, D	lay, Year)	injury		uryat ork? □Yes 2□		28d. Describe ho	w injury occi	urred		
DIVISION OF VITAL RECC To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	t be 28e. Place of Ir	njury - At home, etc. (Specify)	, farm, stree				28f. Location (St City or Town		nber or Rural	l Route Number,	
ospital hours a	Medical (29a. Certifier 1 X Certifying P	hysician: To the best of	of my knowledg	e, death oc	curred at the ti	me, date and	l place, an	d due to the cau	use(s) and ma	anner as state	ed.	
thin 24 thin 24 the Fu	Mec	Check 2 L Medical Exa	miner: On the basis of urse Practitionar: lo	examination and	d/or investic	gation, in my opi	nion, death o	ccurred at	the time, date an	d place, and o	due to the car	use(s) and manner stated.	
P≥₽8		Comen	al M	BBS			se number	009		9d. Date sign	ned (Month, I	Day, Year)	
1 gm		30. Name and address of person wh	o completed cause of	death (Item 23a		int)				NOV,	121		
N.		CHINAZO MEN 31. Date filed (Month, Day, Year)	IRV. 22	SOUTH C	REEL	ne stre	ET, 13P	HTIM	IORE, N	10, 2	1120		
Sta Registr	ar	31. Date filed (Month, Day, Year) NOV 2 0 2012	2 Consum	trar's Signature	barks	/							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 🕕 📗

		•	1 - For Stata Ragistrar	State of	of Marylar		irtment of F tificate of			giene Rag. No.	012	3/28	B
			1. Decedent's Name (First, Middle	le, Last)					2. Date of De.	ath Day	Year	3. Time of Dea	ath
·	Physici Medio/		Mary L. Kanara	as					Novembe		, 2012	5:35	A ^M
	Examir		4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town, o	Location of Deat	th	4c. County of Death			
			Edenplace 5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	Towson If Under 1 Year	If Under 24 Hrs	8. Date of Bird	de .	ltimore		oreion
	uneral irector		059-24-6597	1 □ M 2 🔀 F	91	Yrs.	Months Days	Hours Min		y. Year)	921	nplace (State or Fo untry) Greece	e.e
70			Usual Residence of Decedent		<u> </u>				popor 2	-, -			
arylan	whow	_	10a. State 10b. County	,	10c. Ci	ity, Town or Lo	cation					10d. Inside City L	
he M	Ba-f	ecto	MD Baltin	nore	Tov	wson	100 7: 0:4:			10- 04			
with t	a or i	ā		Pond			10f. Zip Code 21286			USA	zen of What Co	unity ?	
death	ms 23	Funeral Director	800 Southerly 11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13. \	Vas Decedent of H	ispanic Origin? (5			14. Race - Ame		
after	or ite		1 ☐ Never Married 2 Mar	ried Armed F 1 Yes If Yes, G	2 X No		Yes, specify Cuba	an, Mexican, Puer Specify:	to Hican, etc.)		Black, White	a, etc.	
G 61613-UUSO filed within 72 hours after death with the Maryland Hvijene.	urai.	d by	3 ☐ Widowed 4 ☐ Divorced	Year or I	Dates:						wn	ite	
72 u	"nat	Completed	(Specify only highe	nt's Education est grade completed,		16a. Deced (Give	lent's Usual Occup kind of work done OO NOT use retired	ation during most of wo d)	rking	16b. Kind of Business/Industry			
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filed by H	othe ant,	BeC	17. Father's Name (First, Middle,	Last)		12.02.00	0		me (First, Middle,				
Viand buld be fift Mental Hy	rked tic e	To B	Evangelis Kiriakopoulos Georgia Cargakos										
Nary d 2 sho th and /	is me		19a. Informant's Name/Relations				g Address (Street					lip Code)	
e, P	nm 27 har tr	9	Peter L. Kanan	ras, II	son	-	eaverban	k Circle	; Towson		21286 cation - City or	Town State	
ages of of h	or of		1 Burial 2 Cremation	3 Removal from	State	cemetery, cren	natory or other plac	1 .					
Saltimor sermit. Pages Separtment of	important: If itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or othar traumatic evant, the Medical Examinar must be notified at once.		' 4 □ Donation 5 □ Other (S		ent Dul		Ley Mem Gat . Name and Addre		4/2012	Timo	nium, M	ம York Roa	h
Dec Dec	E P O		· Vett	ULO			ck Towso		1 Home,	Inc.		on, MD 21	
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that	caused the dea	th. Do not ent	or the mode of dyin	ıg, such as cardia	c or respiratory a	rrest,		Approximate Interval Betwee	en
Phy	sician		Immediate Cause (Final disease or condition	Pa	rKins	ins i	with c	lemen	tra			20 i Ma	
	edical miner		resulting in death)		(or as a consec	quence of);	. (2 1	, -			2	
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ַ שַ		0.0	IF FEMALE:							T			700
death cer	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy								23d. Date of deli Month	very Day Year	ır.
be de	the ched	ysic	1 □ Yes 2 No 9 □ Unknown	9□ Unkr		death 5	Other (specify)						
The law requires that the	been signed by the attending should be detached for use a	by Ph	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco u	ise contribute to	the cause of deat	h?
COLUS, w requires t	an sign								10,	Yes 2	No 3□Pr	obably 4 Unkr	nown
a CC	s bee 2 sho	ompleted							24a. Was	an	24b. Were au	topsy findings ava- completion of cause	ulable
	ate ha	Com								rmed? 2 X No	death?		0 0.
VIICIAN:	ertific actor,	Be (25. Was case referred to medical examiner?				0.11	5	ath (Check only o	one)			
Oi VIIA Physician:	After this certificate has funeral director, page 2.	2	1 ☐ Yes 2 No 27. Manper of Zeath	Hospital: 1 28a. Date		ER/Outpatien	t 3□ DOA Oth	4 Nursing	Home 5 Resi			city)	
e G	After	tion	1 Natural 5 ☐ Pendii		nth, Day Year)	Injury	Wor	k? Yes 2□No	EUG. Describe	1044 111141	y occurred		
Attan	ector: by the	ertification;	3 ☐ Suicide 6 ☐ Could	not be 28e. Plac	e of Injury - At h	nome, farm, str	eet, factory, office					ıral Route Number	ή,
alor s afte	od in t	Cert	4 Homicide	build	ling, etc. (Speci	ny)			City or To	wn, State	,		
TO the Hospital or Attanding within 24 hours after death.	To tha Funaral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 2 Medical	ng Physician: To th	e best of my kno casis of examination	owledge, death ation and/or inv	occurred at the tir restigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
o the	o tha	Mec	29b. Signature and title of certific		RIGI STATEU.		29c. Licens	e number		29d. Da	te signed (Monti	n, Day, Year)	
F \$	-0		Exeller	to, c	RNF	7	RIF	18191		11/	19/2	012	
			30. Name and address of person	who completed cau	se of death (Ite	m 23a) (Type,	Print)	0.	Tarris	1	mw -	11057	
	- 0-	1	31. Date filed (Month, Day, Year,	C 10 U1	Registrar's Sign		outherl	y Ka	, 10WS	01	md. a	11036	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month : 45 PM Vovember 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Nursing 12abeth Center timor 5. Social Security Number 8. Date of Birth (Month, Bay, Year) May 13, 1924 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 F 219-16-9333 88 Director Maryland May Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director Maryland Baltimore Catonsville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 405 Gralan Road 21228 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married 1 ☐ Yes 2x No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify: Specify. "natural", 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Microfilm Association Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Charles W. Chetelat Edna F. Wunder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau 405 Gralan Road Catonsville MD John Knauer/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Most Holy Redeemer 1 X Burial 2 Cremation 3 Removal from State 11/16/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore MD 22. Name and Address of Facility Leonard J. Ruck, 5305 Harford Road 21. Signature of Funeral Service Licenses Inc. Baltimore MD 23a. Part 1. Enter the dileast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OVUNMY disease or condition Medical resulting in death) Due to (or as a consequenc yof): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): ending physician and use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Year Day 124 hours after death.
e Funeral Director. After this certificate has been signed by the a student filled in by the funeral director, page 2 should be detached it 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 110 Hirbeidism 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? erzure 24a. Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Acciden 5 Pending injury 1 🗌 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 🛴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 Vovember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 3320 Avenue. enson Registrar's Signat State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November William Frank Luebberman 8:10P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carrol1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 220-42-6551 Country Director 1**X**□M2□F July 6, 1946 MD ms 23a or 28a-f show must be notified at 10a. State 10b. County with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director MD Carrol1 Sykesville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7361 Gaither Road 21784 USA items death al Hygiene. d other than "natural", or items event, <u>the Medical Examiner m</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give à 1 Never Married 2 X Married Black, White, etc. within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Public Safety Firefighter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, William E. Luebberman Betty Metzger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai once. Mrs. Elizabeth Luebberman (Wife) 7361 Gaither Road Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springfield Cemetery! 11/24/2012 Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licenses PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications of at cau shock, or heart failure. List only one cause on each ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in Jury that initiated events Examine Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 4 Pregnant at time of death 9 Unknown 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ been sig 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? r this certificate has beral director, page 2 s 24a. Was an autopsy 1 ☐ Yes 2 ☐ 100 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence ဂ္ 1 🗌 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certific (Checl only or 3 Certifying Nurse, Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signati and title of certifie

State Registrar 31. Date filed (Mont)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death. Physician/ North V 0495 55 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 40 Ne S (5a mo N/A 1-1 If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Min. Director 212-58-0761 1 □ M 2 🗓 F 61 Yrs 1951 20, Maryland Apr. Usual Residence of Decede permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Machical Experiments 20 or 28a-f show once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland N/ABaltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 United States 2413 West Patapsco Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 🕅 No Specify Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gladys Henry Robert Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2413 W. Patapsco Avenue, Baltimore, Maryland 21230 Jacob Lonas / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 D Burial 2 X Cremation 3 D Removal from State Metro Crematory Inc. 11/19/2012 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Peath Immediate Cause (Final Physician/ disease or condition resulting in death) Hemory Na Medical Due to (or as a consequence of) Examiner VO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
5 ☐ Other (specify) _____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. tor: After this certificate has been signed the funeral director, page 2 should be de-23e. Did tobacco use contribute to the cause of death? Completed by tai neumothorix 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 🗌 Yes ျု 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending death. within 24 hours after death.

To the Funeral Director: At completely filled in by the fu ☐ Accident Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 2012 address of person who completed cause of death (Item 23a) (Type, Print) 4000 Annaf ma 11001110 0)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3:38 P M <u> Margaret G. Lichtfuss</u> November 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Oak Crest Care Center Parkville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, Year)

January 17, 1924 Hours 218-16-1811 Director Baltimore, Maryland 1 □ M 2 🔀 F ೩೩ or then "neturel", or iteme 23e or 28e-f ehow The Medical Examiner must be notified at within 72 hours efter death with the Merylend 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Parkville 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8830 Walther Blvd. United States 21234 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 2 21215-0036 1 ☐ Yes 2 X No Specify: 3 √ Widowed 4 □ Divorced Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Henry Becker Gertrude Kunze 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Gulick (Daughter) 8769 Bastable Mill Road Catlett, Virginia 20119 Baltimore, 20a. Method of Disposition November 24, 20c. Location - City or Town, State permit. Pege 1
Depertment of Importent: If II eny injury or o cemetery, crematory or other place)
Dulaney Valley Memorial
Camers 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Timonium, Maryland 21. Signature of Fyneral Service Leans Name and Address of Eacility Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or conshock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final disease or condition resulting in death) Physician/ erebrovaxulo Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical 68760 The lew requires that the deeth certificate IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Day 9 Unknown 9 Unknown P.0. δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an hes After this certificete Hospitei or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of 1 Natural 5 Pending deeth. ☐ Accident Investigation Director: 3 Suicide 6 Could not be in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours eff
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compietely filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 9 30. Name and address of person who ca

DHMH 17 Rev 06-2011

State Registrar

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Margaret

Ivd , Parkville MD 2/23

			For State	State of Ma	aryland / Dep	artment of H			giene Reg. No. 2	012	27202
	*		Registrar 1. Decedent's Name (First, Middle,	Last)		tinouto or E	- Cutir	2. Date of De	ath	UIC	3. Time of Death
	Physicia		Daniel L	Sago				Novem	Day	Year 2012	4:14 PM
	/Medic Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Dea	ath	4c. Cou	inty of Death	
wie.			Johns Hopkins Bay			Baltimore		L. L. D. L. D.		N/A	(0)
	Funeral		5. Social Security Number 521–32–4852	1 📉 M 2 🗆 F	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month, Da	y, Year)	Count	**
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death with the Maryland	ns 23 must	Funeral	1608 Oakway	12. Was Decedent F	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		(Specify Yes or No-		ted Sta	
after d	or iter		1 ☐ Never Married 2 ☐ Marrie	Armed Forces? d 1 XYes 2 □ N	No	If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	n, Mexican, Pue Specify:	erto Rican, etc.)		Black, White, e	
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Mar d 2 sho	and is m		19a. Informant's Name/Relationshi Mr. Daniel D.		Sonl	ing Address (Street a					
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ages	nent of h		1 ∑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.			osition (Name of matory or other place	:			•	
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r e		Con						1 🗌 Yes	ormed? 2 No	death? 1 ☐ Yes	2 🗌 No
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	this	5	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inju		of 28c. Injury	y_at	Home 5 Resi			<u> </u>
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1	0 1, Ou		30. Name and address of person v		death (Item 23a) (Type	, Print)					
1	·		2	PMO	ala Ciara t		4940	Eastern A	venue,	Baltimor	e, MD, 21224
	Sta Registi		31. Date filed (Month, Day, Year)	2 A 32. Registra	ar's Signature						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:30 P M Elizabeth Aileen 2012 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Harmony Hall Columbia Howard If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea 1 ☐ M 2🗓 F Months Days Hours 1930 Maryland Director 578-36-2415 82 Aug. Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and I is marked other than "natural", or items 23a or 28a-f show 10a State 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Prince George's Beltsville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4403 Yucca Street 20705 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Completed 3 Widowed 4 X Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Seconday (0-12) College (1-4 or 5+) 12th Ø Administrative Assistant Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles S. Lee Julia E. Hopkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles K. Combs/Son Nightmist Court, Columbia, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. John's Cemetery 11/27/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 20707 Talbott Avenue, 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physicianz disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo 5 Other (specify) Month Day Year Pregnant at time of death page 2 should be detached been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed within 24 hours after death.

To the Funeral Director: After this certificate hompleted filled in by the funeral director, page 2 XNo Yes 2 X No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Assisted Other: 4 \square Nursing Home 5 \square Residence 6 XOther (Specify) Living 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Lazris 31. Date filed State

29a. Certifier

(Check

29b. Signature and title

Certifying Nurs

of certifier

6334 Cedar Lane, #103, 32. Registrar's Signature

Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Columbia,

21044

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 16, 2012 7:20 a M Margaret Ann Lucia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville 5837 Tudor Lane If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 14, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min. Days Scotland 215-58-8054 Director 1 □ M 2 🛣 F 63 I Hygiene. other then "netural", or items 23e or 28e-f shov vent, the Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🖳 Yes 2 🗌 No Rockville MD <u>Montgomery</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20850 15315 Diamond Cove Terrace #5 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Food Service/Restaurant Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be filed hand Mental H ris marked of မ Margaret Ann Story Reid William Beattie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 end 2 sh Department of Health ar importent: If Item 27 is eny injury or other treu once. 15315 Diamond Cove Terr. #5 Rockville, MD 20850 Pauline Lucia/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crematory 11/17/12 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 MD 21029 MO1251 Beverly L. Heckrotte P.A. Clarksville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Deatl Immediate Cause (Final nset and Death MONTINS Physician/ disease or condition Lung Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami The lew requires that the death certificate be executed Cause (Disease of Injury that initiated events buriel-trar Due to (or as a consequence of): resulting in death) Last attending physiclen for use as the burie Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death ed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pleted I 1 √ Yes 2 □ No 3 □ Probably 4 □ Unknown cate has been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Friend's 1 🗌 Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 🗷 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) November 16, 2012 D43083

Registrar

DHMH 17 Rev 06-2011

State

9707 Medical Center Dr. #300 Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

George Sotos, M.D.
31. Date filed (Month, Day, Year)
NOV 2 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month // Physician/ James H. Lindsay 1439 4a. Facility Name (if not institution, give street and number)
\$1, AGNES HISDITAL Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A 8. Date of Birth (Month, Day, Year) NOV 20, 1930 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Director 1 XM 2 XF 81 MD There 1 and 2 should be filed within 72 hours enter water the filed within 72 hours enter water freely end Mental Hygiene.
Thenti If them 27 is merked other then "neturel", or items 23e or 28e-f show thenti If them 27 is merked other then "neturel", or items the notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai USA 21213 1832 N. Broadway 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married Completed by Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction N/A Laborer 12th B 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Lindsay Lois Spriggs 19a. Informant's Name/Relationship (Type, Print) Ernest Lindsay/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 127 First St #108 Rochester, NY 1460 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XDABurial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Depertment o Important: If eny injury or Mt Zion Cemetery 11/29/12 Landsdown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beverly D. Cromar 2700 Edmondson Ave. Balto., MD e F/S 21223 Cromartie 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HEMORRHAGIC disease or condition menon Medical resulting in death) Due to (or as a consequence of) Examiner 24STROINCESTINA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sete hes been signed by the ettending physician end page 2 should be deteched for use es the buriel-trensit The lew requires that the deeth certificate be executed Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ Box in the past 12 months? Month 9 Unknown 9 Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ briknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' To the Hospital or Attanding Physicien: The within 24 hours after deeth.

To the Funeral Director After this certificate of completely filled in by the funeral director, peg 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** BB 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) [호 1 🗆 Yes 2 100 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

CEDRIL DARK

31. Date filed (Month, Day, Year) NOV 2 0 2012

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BALTMORE

2012

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NOVEMBER

MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death **Baltimore** N/A 2220 Dukeland Street 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days Min. Year **Director** 216-52-9480 1 **X**M 2 □ F 62 MD Aug 10, 1950 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director **Baltimore** 1 X Yes 2 □ No MD **Baltimore City** 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 2220 Dukeland Street 21216 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1. Marital Status Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: Black 3 Widowed 4 X Divorced Specify: Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medicall once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Roberta Fowkes James Emory 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2220 Dukeland Street Baltimore, MD 21216 Jewel Lindsev 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗴 Burial 2 🗆 Cremation 3 🗆 Removal from State Mt. Zion Cemetery Nov 21, 2012 Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sign tura Tuneral Service License 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that complications ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each Onset and Death Immediate Cause (Final OBSTRUCTIVE P VLMOHARY DISEAS Physician/ ONIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner quentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transi that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be exect within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): resulting in death) Last Physician/Medical as the IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ signed by the atter in the past 12 months? Month Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DM 85 WU 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of page 2 : performe death? 2 🗆 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 10 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 🔲 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signajure and title of certifie

State Registrar

31. Date filed (Month, Day, Year)

NOV 2 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NISHAP SOREY 2-300 GANGS ON

200244

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5,20b per fh g933 11-27-12 yt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day 10:25AM Jerome Guanti Mills 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A Baltimore
If Under 1 Year If Under 24 Hrs. Preston Street 5. Social Security Number 219-58-3421 9. Birthplace (State or Foreign 8. Date of Birth Funeral (Month, Day, Year) Months Days Hours Min. Country) Director 1 🕱 M 2 □ F 58 /23/1954 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 501 E. Preston St. Apt. 627 21202 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene, Elementary/Secondary (0-12) College (1-4 or 5+) 12th Some Coll Disabled Be permit, Page 1 and 2 should be filed Department of Health and Mental Hy important: If Item 27 is marked oth any injury or other traumaths areas 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Aaron Kelly Myrtle Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sallie Lovelist- Sister 2235 E. Jefferson St. Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 11/26/2012 Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H East 01 East North Ave Baltimore Md 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 9 a Physician/ 1 disease or condition Medical resulting in death) Due to lor as a consuluence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and the buriat-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown be detached for Month Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 2 No 3 Probably 4 Unknown Completed 1 Tes certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform performed? 1 ☐ Yes 2 ☐ No å 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 1 Sesidence 6 \(\text{Other (Specify)} \) Hospital: 2 🗌 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending death. ☐ Accident☐ Suicide Investigation filled in by the Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined within 24 hours after To the Funeral Direct City or Town, State) Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Dertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 29c. License numbe 29d. Date signed (Month, Day, Year) 1501 W M s of person who completed cause 32. Registrar's gnature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 12:50a M Angelo Vito Mandris 201 20 Nov Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heritage Genesis Baltimore Dundalk 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 212-30-6292 79 1 🛛 M 2 🗆 F 5-18-1933 PA Yrs and Marial Hygiana. Is marked other than "natural", or frems 23s or 28s-f show sumatic evant, the Medical Examiner must be notified at 10a. State 10b. County should ba filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 1 🖾 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 3814 E. Pratt Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) City of Baltimore Contractor 12th Be other traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nick Mandris Anna Tozano 19a. Informant's Name/Relationship (Type, Print) $ext{sister}$ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224 permit. Paga 1 and 2 shv Dapartmant of Haaith an Important: if Item 27 is any injury or other traus Helen T. Mandris 3904 Claremont St., Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 11-24-12 Baltimore, MD 4 Donation 5 Other (Specify) Oak Lawn 21. Signature of page ral Service Licensee 22. Name and Address of Facility Joseph N. Zannino Jr. FH 263 S. Conkling St. Baltimore, MD 21224 22. Name and Address of Facility Joseph N. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GREBRO VASCULAR Ppysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): €xaminer PERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the attanding physician and the for use as the burlail-transit or Attanding Physician: The law requires that the death certificate be executed Due resulting in death) Last TAMOUS CELL CAMCER OF NECK Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month datachad 9 Unknown ፩ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ata has been signad paga 2 should ba da 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe within 24 hours after death. To the Funeral Director: After this cartificata I complataly filled in by the funeral director, pag 25. Was case referred to medical 8 26. Place of Death_(Check only one) examiner? 2 No 1 Yes Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, 5 Pending **Natural** work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation is an examination and/or investigation in the cause (s) and manner as stated. Medical 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one 29b. Signatur 29d. Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print) 30. Name and address of person who cor law Dun derlu Mos

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 C. Elzie Martin, Jr. 5:58 A November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Gilchrist Center of Howard County Columbia If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** Days (Month, Day, Year) Director 216-24-0669 1 🕅 M 2 🗆 F 82 19, 1929 Dec. Maryland parmit. Paga 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiana. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, the Medical Experience. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director West 1 Tes 2 No Martinsburg Berkelev Virginia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 25401 United States Ours Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces Black, White, etc. V Yes 2 □ No 1952 Yes, Give Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🎇 No Specify: Specify: White 3

Widowed 4 □ Divorced 1959 Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Thompson Steel Steel Worker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Esther Grammer C. Martin, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10204 Fairway Drive, Ellicott City, Maryland 21042 Leona L. Smith / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 11/19/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland Inc 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law raquires that the death cartificate be executed ed by the attending physician and detached for use as the burlal-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) N C 5 OL C 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 1 Yes 2 No 5 Pending Hospital or Attend 24 hours after daath
 Funeral Director: A Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) fillad in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completaly fi 🗹 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 17 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10± 6701 N. Charlis forus u Cus LEV VEY

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year) =

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Name (First Middle 2. Date of Death 3. Time of Death Physician/ Month Day Medical . Eacility Name (if not institution **Examiner** County of Death celti nese 8. Date of Birth (Month, Day, Birthplace (State or Foreig Country) 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 🗆 F 246-56-5217 73 Yrs Director Usual Residence of Decedent 28a-f show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director notified MD Baltimore Randallstown 1 Yes 2X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? þe 23a Funeral with 9109 Liberty Rd. Examiner must 21133 U.S.A. items death v 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō 1 X Never Married 2 Married þ 1 Yes If Yes, Give hours after Maryland 21215-0036 1 Yes 2 No Specify. "natural" 3 Widowed 4 Divorced Completed Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done duning most of working life. DO NOT use retired) within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Maintenance 10 UNK traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilbert McNeil, Sr. Febery Mathis Page 1 and 2 should I ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any Injury or other trau Brenda McNeil-Bowie (Sister Retinue Ct. 6 Unit 202 Balto., MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date ' 1 Burial 2 XCremation 3 Removal from State Crematory On-Site 4 Donation 5 Other (Specify) Baltimore, re of Funeral Service Name and Address Joseph 2140 N. · Brown Jr. Fulton Funeral Home Ave. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Stu Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a consequent of) Examiner Sequentially list conditions. Disk to for sels consequence of If any leading to immediate cause. Enter Underlying Exami executed Cause (Disease or iinjury that initiated events burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 phys the b attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, or Attending Physician: The law requires Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform Yes Division of Vital To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 25 Other 1 Inpatient 2 ER/Outpatient 3 DOA rsing Home 5 Residence 6 Other (Specify) After this funeral Manner of Deal Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Tes 2 No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Firtifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29h 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vovember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** samuritan Haspirta Baltimore timore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** 217-24-0269 Director 1 M 2 D F Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at **Funeral Director** timore 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? Black, White, etc. ò þ 1 Neyer Married 2 Married Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Yes 2 ☐ No Maryland 21215-0036 1 Yes 2 No If Yes. Give 3 ☑ Widowed 4 ☐ Divorced Completed Blac Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 oure 19a. Informant's Name/Relationship (Type, Prin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau heila Kimore, MD 21206 Saltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-26-2012 0W501 Signature of Funeral Service Licensee C. Greene Funeral Services 22. Name and Address of Facility Vaucha 4905 HIMORE, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or se a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events the burial-tra resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No I Director: A Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) Darah Bivo 31. Date filed (Month, Day, Year) 32. Registrar's State Registrar NOV 2 0

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Meyers, William Fred 2012 5:25 A M Nov. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Center Towson If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. (Month, Day, Year) Director 219-10-2764 1 X M 2 □ F 88 Jan. 9,1924 Maryland Usual Residence of Decedent ir than "neturel", or items 23a or 28a-f eho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after deeth with the Maryland Director 1 Yes 2 X No MD Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4014 Keeners Road 21220 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. d Mental Hyglene. merkad other than "neturel", matic evant, the Medical Exc. Specify: 3 Divorced WWII White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) North Point Elementary/Secondary (0-12) College (1-4 or 5+) Business Owner 10 Years Liquors Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ ba Oscar A. Meyers Anna Weber or other treumatic of Health and Nitem 27 Is me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4014 Keeners Road Middle River, MD Mrs. Anna M. Meyers(Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Paga 1 Departmant of Important: If it any injury or o ₽ 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Holly Hill Mem. Gdns. 11/24/2012 Middle River, MD 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
Dundalk Maryland 2 21. Signatura of the ral Service Licensee Khar Fisher Dundalk. 23a. Part 1. Enter the disease, or complications that glused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and I for usa as tha burial-transit Exam • Hospital or Attending Physicien: The law requires that the death certificate be executed 124 hours eftar death.
a Funeral Director: After this certificate has been signed by the attending physician and letaly filled in by the funeral director; page 2 should be deteched for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Pregnant at time of death 5 Other (specify) q 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records. 1 Yes 2 No 3 Probably 4 thknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 110 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 👱 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completaly. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 To the F 3 🗆 Çertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certific 29c. License numbe 29d. Date signed (Month, Day, Year, tim 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 32. Registrar Signat State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Matlat November Physician/ Day 15, 2012 Evelvn Dixie 9:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Baltimore City Parkville 2907 Glendale Avenue 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 214-40-1843 Director 1 M 2 X F 100 March31,1912 South Carolina an "natural", or Items 23a or 28a-f show Wedical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. 4 Other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dunda1k MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zin Code 10q. Citizen of What Country? Funeral United States 21222 8320 Bletzer Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) g, Service Station 8 Years Business Owner 27 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unkn . I and 2 should be file I Health and Mental H Item 27 is marked of ္ဝ unkn. White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2-2-2-2 Pond Dundalk. MD 21222 19a. Informant's Name/Relationship (Type, Print) 7402 Old Battle Grove Road Dundalk, MD Michael P. Tyson(Friend) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit, Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Hilltop Service Corp. 11/19/2012 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Scott P. 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc 7922 Wise Ave. Dundalk, Maryland 21222 Gardner 300 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ AKTERIOSCLEPOTIC disease or condition COFENARY APPREAM Medical resulting in death) Due to (or as a consequence of): Examiner IMBETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Vear 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTA 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 2 10 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Caregiver's Residence ê Other: 4 Nursing Home 5 Residence 6 🖾 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural
2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

hours after death. uneral Director: After this certificate has To the Hospital or within 24 hours at To the Funeral D

completely

Medical

30. Name and address of persor

9101

29a. Certifier

4 Homicide

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

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ed cause of death (Item 23a) (Type, Print) DR-205 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DOU 2919

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

City or Town, State)

29d, Date signed (Month, Day, Year,

5. BALTIMOR

State Registrar 1 - For State Registrar

		1. Decedent's Name (First, Middle, Last)			Date of Death Month	n Day Year	3. Time of Death	
Physicia /Medic		CHARLES MORAN			November 4 20			
Examin		4a. Facility Name (If not institution, give street and number)		Location of Death	4c. County of Deat	h		
<i>-</i>		Johns Hopkins Bayview Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthde	Baltimore If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	N/A 9. Birt	hplace (State or Foreign	
Funeral Director		214-38-9281 1 XM 2 F 70 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan. 7	1942 Ma	hplace (State or Foreign Intry) ryland	
fand t		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits	
Mary a-f sh ied a	tor	MD Baltimore		Dund	a1k		1 ☐ Yes 2X No	
or 28%	Jirec	10e. Street and Number	10f. Zip-Code			g. Citizen of What Co	untry?	
23a sst be	ral	1715 Pin Oak Avenue	21222	2		United St	ates	
er mi	Funeral Director	Armed Forces?	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (Spe an, Mexican, Puerto I	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White		
rs afte	by F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates;	1 ☐ Yes 2 🗽 No	Specify:		Specify:	White	
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show nt, the Medical Examiner must be notified at	ted		ecedent's Usual Occup	pation		16b. Kind of Business		
thin 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	e. DO NOT use retired	during most of work	ng			
ygien ygien her th		8 Years F	ressman	18. Mother's Name		Box Factory		
be fill ad oth even	Be	Thomas Moran			e Skillr			
hould d Mer mark natic	욘		ailing Address (Street			Cify or Town, State, 2	Zip Code)	
nd 2 s Ith an 27 is			15 Pin Oak				21222	
s 1 ar if Hea item			isposition (Name of crematory or other place	[[Date 2	20c. Location - City or	Town, State	
Page nent c int: If		4 Donatjon 5 Other (Specify) Hillto	p Service	Corp. 11/1		Towson, M	•	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee Gregory E. Reed	22. Name and Addre	ss of Facility Funeral H	lome of I	Dundalk, I	nc.	
6 2 2 2	_	23a. Part 1. Enter the disease, on complications that caused the death. Do not	7922 Wise	Ave. Du	ndalk,Ma	aryland 2	1222 Approximate	
		shock, or heart allure. List only one cause on each line.	enter the mode of dyn	ng, such as calculact	or respiratory arre	351,	Interval Between Onset and Death	
Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):						
Examiner		NOW - SMA AL CO		mrec				
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying						
ocuted nd transi	Examiner	Cause (Disease or injury that initiated events c			_			
oe execian a		resulting in deatify Last Due to (or as a consequence of).						
icate physi is the	edic	d						
nding use a	ian/Medical	IF FEMALE: 23b. Was decedent pregnant in the post 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	2 □ Estenia programa	7/		23d. Date of delivery		
death	Physici	1 Yes 2 No	5 Other (specify)			Month	Day Year	
at the		9 Unknown Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause g	iven in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?	
signed	d by		, , ,		1 ▼ Ye	s 2 No 3 P	robably 4 🗌 Unknown	
w requ	Completed				24a. Was an		utopsy findings available completion of cause of	
he lay e has age 2	шо				autops perform			
ian: 1 rtificat ctor, p	Be C	25. Was case referred to medical examiner?		26. Place of Death				
hysical	2	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpa	atient 3 DOA Oth	4 Li Nuising nui		nce 6 Other (Spe	cify)	
ing P	ion:	27. Manner of Death Natural 5 □ Pending (Month, Day Year) Natural investigation 28a. Date of Injury (Month, Day Year)	ıry Wor		28d. Describe ho	w injury occurred		
death ctor: / y the	ficat	3 Suicide 6 Could not be 28e. Place of injury - At home, farm,				reet and Number or F	ural Route Number,	
al or A s after I Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)			City or Town	, State)		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (29a. Certifier (check only one) 1. Certifying Physician: To the best of my knowledge, dependent on the basis of examination and/content on the basis of examination						
To the vithin To the compl	Me	29b. Signature and title of certifier	29c. Licens	e number	25	9d. Date signed (Mont	h, Day, Year)	
1/\04		un so	R	ES-000		11/14	2012	
10/1		30. Name and address of person who completed cause of death (Item 23a) (Ty	rpe, Print)	4040 =	octors A	anua Paltim	oro MD 01004	
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	11	4940 E	astern AV	cilue, Dalum	ore, MD, 21224	
Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature	parks					
HMH 17 Rev 1/20	001	1101 1101						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012

DHMH 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 2012 Beatrice Morris 5:50 A M L. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dunda1k Baltimore Genesis Heritage Nursing Home 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Director 1 M 2 X F <u>575-16-7722</u> Oct. 8,1924 Hawaii Hygiene other than 'netural", or items 23s or 28s-f show vent, the Medical Examinar must be notified at 10a. State 10b. County filed within 72 hours efter deeth with the Meryland 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No MD Baltimore Dunda1k 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 21222 United States 2808 McComas Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: Hawaiian 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Health Care Elementary/Secondary (0-12) College (1-4 or 5+) Provider Registered Nursing of Heelth and Mental Hygle of Heelth and Mental Hygle of Item 27 Ia merked other if other traumetic event, III 12 Years Years 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harriet Kalolukea Achong Kia Siang 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2808 McComas Avenue Dundalk, Maryland 21 19a. Informant's Name/Relationship (Type, Print) 2808 McComas Avenue Mr. Ronald K. Morris, Sr. (Son) Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pega 1.
Department of I
Important: If it
eny Injury or of 1X Burial 2 Cremation 3 Removal from State Garrison Forest V.A.Cem12/3/2012 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Justin Ave 7922 Wise Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physicien end I for use es the buriei-trensit Exami The lew requires that the deeth certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death signed by the at 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nonknown Completed efter death. Diractor: After this certificete hes been si d in by the funerel diractor, pege 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 Yes 2 No or Attending Physician: To Be 25. Was case referred to medical of Vital 26. Place of Death (Check only one) 1 🗆 Yes 2 110 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident 3 Suicide 4 Homicide To the Hospital or Atter within 24 hours efter des To the Funaral Diractor completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature-and title of certifier

12 m

State

Registrar NOV 2 0 2012 August A. Again

30. Name and address of person

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:00p _M Charles Martin Physician/ Month Nov 11, 2012 Year Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore** 201 North Washington Street, Apt 510 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** Jun 13, 1941 Days Hours Min MD 218-36-1691 71 Director 1 M 2 F Usual Residence of Deced 28a-f show 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location death with the Maryland Director **Baltimore** Examiner must be notified MD **Baltimore City** 1 🖺 Yes 2 🗌 No 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a U.S.A. Funeral 201 North Washington Street, Apt 501 21231 "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No filed within 72 hours after Baltimore, Maryland 21215-0036 Black Specify: 3 Widowed 4 Divorced Specify Completed injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working (Give King of Woln Colling) life. DO NOT use retired) General Laborer permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea ones, Elementary/Secondary (0-12) College (1-4 or 5+) National Brewery Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ **Burtis Martin** Ola Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 Morgan Elis Way, Baltimore, MD 21206 119 Morgan Elis Way, William Martin 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Nov 24, 2012 Windsor Mill, Md. King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Signature of F and al Service Licensee 23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. n. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ 10 Cay disease or condition Medical resulting in death) Due to (or as a cops Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to tor as a consequence of Exami attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O, Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Dav 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform No the mours after death.

Within 24 hours after death.

To the Funeral Director. After this certificate I 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined

State

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

NOV 20

2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Y-CART

Registrar DHMH 17 Rev 06-2011 3100

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mariner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Michael Joseph Murphy, Jr. 2012 Medical November 09:15 AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7978 Nolcrest Road Glen Burnie Anne Arundel Co. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days (Month, Day, Year) 213-84-5436 **Director** 1**X** M 2 □ F 53 08/18/1959 Maryland Usual Residence of Decedent important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Anne Arundel Co. Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7978 Nolcrest Road 21061 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. State Highway Elementary/Secondary (0-12) College (1-4 or 5+) yrs. Supervisor Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of ဂ Michael Joseph Murphy, Sr. Sandra Lee Kestler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 si of Health a item 27 i Mrs. Colleen M. Morgan /Sister 160 Maryland Avenue Pasadena, Maryland 21122 permit. Page 1 a Department of H Important: If itel 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem. Park | 11/21/2012 Glen Burnie, MD Signature of Funeral Service License 22. Name and Address of Facility 1 2nd Ave SW, Glen Burnie, MD M01121 Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only on cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buris Physician/Medical that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas certificate ! 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica etely filled in by the funeral director, 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 2 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natura! 5 Pending 1 Yes 2 No 2 Accident 3 Suicide 4 Homicide Investigation the Funeral Directory filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

DHMH 17 Rev 06-2011

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Kathleen Louise Murphy 6:05 pm 2012 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery 9. Birthplace (State or Foreign Country) Ohio Social Security Number 8. Date of Birth (Month, Day, Year) 09/15/1922 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 1 □ M 2 🕱 F 90 Ohio 484-16-3907 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No Maryland Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 301 Russell Avenue 20877 u.s.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 ☐ Yes 2 💢 No If Yes, Give Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Specify: Caucasian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vera Fern Hines William P. Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14303 Rectory Lane, Upper Marlboro, Maryland 20772 Mary Hila Snyder - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 D Burial 2 X Cremation 3 D Removal from State Lincoln Crematory 11/23/2012 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852 or complications that cach 23a. Part 1. Enter the disease ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final Onset and Death Lailure to Th 'tysician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 After this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical å 26. Place of Death (Check only one) examiner? Other: ည 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient Certificate: 27 Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifier 104115 201 RUSSELL AVENUE GAITHERSBURG, MIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BIRSCHBARLE, u

Registrar

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Day 2012^{Year} Susan Lee Mahone 15 1:45 P Nov. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Olney MedStar Montgomery Medical Center If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Director 266-74-7757 Usual Residence of Dece 1 □ M 2 🔀 F New York Oct. 19,1945 67 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 🗆 Yes 2 🎽 No Gaithersburg the Mary MD Montgomery 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? pe 23a Funeral Page 1 and 2 should be filed within 72 hours after death with USA 20882 8120 Seneca View Drive items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces o. þ 1 Never Married 2 Married Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: SpecifyWhite 'natural", 3 Widowed 4 Divorced Completed Year or Dates dical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Me than Ith and Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Education Grade School Instructional Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Agnes Dades Steven Kachauba 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Department of Health a Important: If item 27 is any injury or other trau once. 8120 Seneca View Dr. Gaithersburg, MD 20882 Richard Mahone/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🗌 Burial 2 🔀 Cremation 3 🗋 Removal from State Final Journey Crematory 11/19/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 M01651 Heckrotte, P.A. Clarksville, MD 21029 Beverly L. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SIS >ac disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (c cause. Enter Underlying Cause (Disease or injury that initiated events the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 Month Day Year Pregnant at time of death signed by the aid be detached for Yes Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed this certificate Yes Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita! Other: 1 🗌 Yes မ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner e Ceath Certificate: 28b. Time of 28c. Injury at After Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director: / 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

DHMH 17 Rev 06-2011

State Registrar

Medical

29a. Certifier

29b.

(Check

30. Name and add

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31. Date filed (Month, Day,

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redical Examiner: On the basis

completed of

Certifying Nurse Practitioner

best of my

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d, Date signed Month, Day Year)

18101 Prince Philip Drive

Olney, MD 20332

knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

12-08603	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Vayne Lee Micha	1	Jr. St - For State Registrar	ate of Maryla		artment of <i>rtificate of</i>			Menta	al Hyg		g. No. 20	2 3731
Physicia	n/	Decedent's Name (First, Midd	le,Last)			=	-		2	Date of Deat		3. Time of Death
Medical Examin		Wayne Lee Michael, Jr. November 12, 2012									2312 hrs	
4		4a. Facility Name (if not institution 3031 Weaver Avenue		umber)	ľ	46. City, Baltir		ocation of	Death			4(1)
Function		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)		er 1 Year	If Under	24Hrs.	8. Date of Birt	n/a h(MM/DD/YYYY) 9.1	Birthplace (State or
Funeral Director						Month		Hours	Min.		For	eign Country Mary Land
	\vdash	216-86-9876 Usual Residence of Decedent	1 X M 2 F	41	Yrs	•	1			Sept 2	6, 1971	Maryland
any	ı	10a. State 10b. County		10c. City	, Town or Locat	ion						10d. Inside City Limits
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Maryland 28a-f show	185	10e. Street and Number				10f. Zip				10	og. Citizen of What C	ountry?
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death with the Maryland or items 23a or 28a-f sho must be notified at once	Funeral Director	11. Marital Status		cedent Ever in U				anic Origir Mexican, F		cify Yes or No-	14. Race - Am White, etc	erican Indian, Black,
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s afte	<u>ام</u>	3 Widowed 4 Dir 15. Decedent's Education (Spe	or Dates:		16a. Deceder		No Occupation		nd of wo	ork done	Specify: Wh	
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5-00 ed wii tygier other	히	17. Father's Name (First, Middle							Name (First, Middle, M	Aaiden Surname)	
be fill ricked ir ked	Be	Wayne	Lee	Mi	chael _			Sally			Ann	Price
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione. Important: If item 37 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at page	의	19a. Informant's Name/Relation									nber, City or Town, St	
md 2 and 2 cm 2 cm 2	ŀ	Sally Ann Barr 20a, Method of Disposition	on/Mother		Place of Dispos					Date Date	reedom, PA	
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Baltimore, permit. Pages lar Department of Hes Department of Hes Diportant: If ite njury or other tr	-	4 Donation 5 Other 2.21. Signature of Furieral Service	pecify:	At	lantic 122 N	Jama an	A Addrose	of Eacility			Glen Bu	
Ba perm Depa Impo	•	Bryan W. Clar	Say		L	emmo:	n Fun	eral	Hom	e of Du	ılaney Val nium, MD 2	ley Inc.
Physician	7	23a. Part I nte the disease, o	r complications that	caused the deat	h. Do not enter t	he mode	of dying, s	such as car	rdiac or	respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
Modest		failure. List only one caus. Immediate Sante (Final disease		one and	A1coho1	Int	toxic	ation	ı			Death
xaminer		or condition resulting in death)		a consequence								
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Box 6876(e death certificate the attending phy ed for use as the b	Sicial		langua	nant at time of c	leath 5 O	ther (Sp	ecify)				1	J.
Bc he dea y the a	Physician/M	Part II. Other significant cond	9011ki		resulting in the	underlyin	o cause di	iven in Par	+ 1	23e Did to	phacco use contribute	to the cause of death?
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/ital	o Be	examiner?	Hospital: 1	Inpatient 2	ER/Outpatien	t 3					Residence 6 🗸 0	ther: Scene
of \	-1	27. Manner of Death	28a. Dat	e of Injury th, Day,Year)	28b. Time of	Injury		y at Work?			how injury occurred	
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Division of Vital Records, pptal or Attending Physician: The law requirents after death. seral Director: After this certificate has been sfilled in by the funeral director, page 2 should	ilici	3 Suicide 6 X Co	uld not be 28e. Pla	ice of Injury - At	home, farm, stre	et, factor	y, office b	uilding, etc		28f. Location (Street and Number of State) 3031 We	Rural Route Number, City aver Ave. Apt 3
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Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b											se(s) and manner as and place, and due t	
To t with To t	Medical	29b. Signature and title of certif	and manner				9c. License				29d. Date signed	
		(Can La.	111				O.C.	M.E.			November 13	2012
T A		30. Name and address of person	n who completed ca	use of death (Ite	m 23a)	1_						
Y			Assistant Medic			altimo	e Street	t, Baltim	ore, N	1D 21223		
St Regis	ate	31. Date filed (Month, Day, Year		Registrar's Signa	bark	,						
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
Henry Webb Malcolm Jr 2. Date of Death 3. Time of Death Henry Physician/ 117116/2012 11:32pM Medical 4c. County of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Gilchrist Hospice Center Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8 Date of Birth Funeral Months Days (Month, Day, Year) 01/09/1934 261-48-0649 78 Director 1 🕅 M 2 🗆 F FL ed other than "natural", or items 23a or 28e-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10b County 10c. City, Town or Location the Maryland Funeral Director MD Baltimore Baltimore 1 Yes 2X No 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code Page 1 end 2 should be filed within 72 hours after death with 1 ment of Health end Mental Hyglene.

Lant: If item 27 is marked other than "natural", or items 23a jury or other traumatic event, the Mexical Examiner must by 21207 2512 Poplar Drive . Was Decedent Ever in U.S. Armed Forces?_ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Yes 2 XNo f Yes, Give Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Organizational Consultant 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Consultant Consultant 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) Sue Crowley 17. Father's Name (First, Middle, Last) Henry Webb Malcolm Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2512 Poplar Drive Baltimore MD 21207 Angeline P. Malcolm Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date permit. Page 1 e
Department of H
Important: If ite
any injury or otl
once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 11/19/12 Glen Burnie MD Atlantic Crem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of huneral Service Licensee ThomasAllenPA 7090 Ridge Rd Hanover MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) . Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): attending physician end for use as the burial-transit or Attending Physicien: The lew requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day ☐ Pregnant at time of death 5 Other (specify) signed by the at Id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate has funeral director, page 2: 1 ☐ Yes 2 ☐ No Vec 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 140 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No s efter death.
I Director: Aff Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in To the Hospitai o within 24 hours of To the Funerel Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🖵 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar

back

MD

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KUNA

31. Date filed (Month Pay Year) 100 2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No I. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ November 18, 2012 Gladvs. Melamed 2:14 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Hospice Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 017-18-7631 Director 1 □ M 2 🚟 91 March 15, 1921 Rhode Island items 23a or 28e-f shov ter must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD North Bethesda Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5550 Tuckerman Lane 20852 USA al Hygiene. d other than "natural", or items event, <u>the Medical Examiner m</u> 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married \$ 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. 3 Widowed 4 Divorced White Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Home treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ည William Riseberg Gertrude Block 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Jeffrey Melamed (Son) 67 Forest Street Manchester, MA 01944 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Page 1 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Importent: If any injury or once. Beth Israel Mem Park 11/21/2012 Waltham, MA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine Street Alexandria, VA 22310 (aft 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest fock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Priysician/ Urinary Tract Infection Medical resulting in death) Due to (or as a consequence of): Éxaminer Alzheimer's Disease Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to for as a constituence of Exami attending physiclan and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year detached the 9 Unknown 9 Unknown Ś Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown cate has been siç r, page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' certificate 1 ☐ Yes 2 ☐ No Yes 2 1 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 ☐ No Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \) Other (Specify Hospice မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funerel Director: After this of the Funerel Director after this of completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🖾 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Nov. 18, 2012 D0063195 mo

State Registrar

arks

6001 Muncaster Mill Road Rockville, MD 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Steven Wilks MD

NOV 2 0 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov Month 14Day 201^Y2" Francis David Mumma 5:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rock Spring Village Nursing Home Forest Hill Harford Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. December 14, 1922 216-16-5569 89 Maryland Director 1 XM 2 - F 27 is marked other than "natural", or items 23a or 28a-f show treumetic event, the Medical Examiner must be notified at ould be filed within 72 hours after death with the Maryland d Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho 10b Count 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 √x No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Colgate Drive 21050 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Christian Donald Mumma Mary Louise Reinhard permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke eny injury or other treumetic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Isennock, Sr. (Friend) 37134 Solitude Dr. Selbyville, Delaware 19975 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. Gdns 11/19/12 Timonium Maryland 21. Signature of Furiern 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Mi. 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ metastali disease or condition Medical resulting in death) Due to (or as a consequence of) **1**€xaminer Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Due to (or as a consequence of): signed by the attending physician and defached for use es the burlal-transit Hospital or Attending Physician: The law requires that the death certificete be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death ☐ Yes 2 ☐ No g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death.

To the Funerel Director: After this certificate hes been signompletely filled in by the funeral director, page 2 should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical examiner? a 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Names Practifioner: To the best of my knowledge, Seeth occurred at the time, date and place, and due to the newsels) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D32259 November 15 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Mont)

2. Registrar's Sign ture

Relois

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 15, 2012 Physician/ 4:25 рм C. Millhausen John Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours (Month, Day, Year) 213-26-9226 84 Director 1 X M 2 D F Aug 10, 1928 Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Paga 1 and 2 should be filed within 72 hours after deeth with the Maryland Director of Health and Mental Hyglene. Item 27 is merked other than "neture!", or items 23e or 28a-f si other treumatic event, the Medical Examiner must be notified. 1 Tes 2 No Fallston MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21047 2109 Buell Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces? Black White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: **'**50**-'**52 Specify. White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired)

Self employed contractor (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lela Steinfelt Millhausen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 212 Locknell Rd., Timonium, MD Mark Millhausen-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of himportant: if ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State 11/20/12 Dulaney Vałley Timonium, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Signature of Funeral Service Licensee William G. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Excerohilum reil Medical resulting in death) Due to (or as a consequence of): Examiner months KETTOM ontaminated Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) physicien end the buriai-transit Hospital or Attending Physicien: The lew requires thet the deeth certificete be axecuted Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the a id ba deteched f g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes After this certificate hes bean sit funerel director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) exeminer? 1 X Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) WSPIC ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural n 24 hours after deeth. a Funerei Director: Afte eietely filled in by the fur UNICAM 1 ☐ Yes 2 ☑ No August 24 2012 Conformated Steroid injection 2 Accident 3 Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide UNKNOWN 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hou To tha Fune completely fi (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST 6701 M 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 19a, per fh, g933 11-20-12 sm State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Zanna 2012 1:05a M Novembe Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner TOP Himore N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Min. (Month, Day, Year) Days 453-56-4855 Director 1 □ M 2 🖾 F 80 01/10/1932 TX or than "natural", or items 23a or 28a-f show the Madical Examiner must be mattled at 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location Director 1 ☐ Yes 2 X No BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 2518 STONE MILL ROAD 21208 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces 1 ☐ Yes 2 🕅 No If Yes, Give 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: should be filed within 72 hours eft. end Mental Hygiene. is marked other than "natural", Specify: WHITE 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only high during most of working Elementary/Secondary (0-12) College (1-4 or 5+) SALES REAL ESTATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . 1 and 2 should be ...
...ant of Health and Me-...
...rant: If item 27 is r...
...ory injury or other tr... ည PAULINE **ISADORE** NEUSTADT KALLISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILTON H. MILLER, JR. /SON 2518 STONE MILL ROAD, BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 e
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP.: 11/20/2012 4 Donation 5 Other (Specify) TOWSON, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 1. Enter the ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or hear railue. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown ours after death. eral Director: After this certificate has been si filled in by the funeral director, page 2 should 24a. Was an autopsy performed 1 Yes 2 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hound to the Funer completely file 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) Orleans St. Baltimore Kalasapudi Kochar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 14 2012 07:35P M MEISTER SHIRLEY Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death BALTIMORE SPRINGHOUSE OF PIKESVILLE PIKESVILLE Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. (Month, Dav. Year) Davs Hours 220-07-7892 Director 1 □ M 2 🕅 F 89 02/03/1923 MD Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 ☐ Yes 2 X No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or than "natural", or items 23a of the Medical Examiner must be Funeral 8911 REISTERSTOWN ROAD 21208 USA death 1 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates Specify: WHITE 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working BALTIMORE GAS & life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ELECTRIC CO. 12 REPRESENTATIVE other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o rage 1 and 2 should be 1 Department of Health and Mental Important: If item 27 is many injury or other ပ HORSHOFF ROSEMAN GEORGE BESSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TANNER COURT, PIKESVILLE, MD 21208 GLENN MEISTER / SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MIKRÓ KODÉSH BETH ISRAEL 4 Donation 5 Other (Specify) 11/18/2012 BALTIMORE, MD ur, of Funeral Serve I 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or confidentions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical requires that the death certificate be P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Year Month Day Pregnant at time of death 2 No the be detached g Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 █ Unknown page 2 should Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ♣No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 Residence 6 Bother (Specify) Assisted (Wigy 1 Inpatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Hospital or Attending Physician: The L 24 hours after death. Funeral Director; After this certificate h Certificate: completely filled in by 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Blac Jaso 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month EILEEN MILLER 0616 A M November 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltmore MOSPITAL OF BALHMORE N/ASocial Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Director 471-38-4997 1 □ M 2 🗓 F 80 06/24/1932 MD r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2903 FALLSTAFF ROAD, #508 21209 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married à 1 Yes 2 No 3 X Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and 2 should be filed within 7. Health and Mental Hygiene. tem 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) MEDICAL SECRETARY MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MILTON KIRSH **FANNYE** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11704 LOVEJOY STREET, SILVER SPRING, MD 20902 INA LERMAN / DAUGHTER Department of Healt Importent: If item 2 eny Injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or oth MIKRO KODESH BETH ISRAEL 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/18/12 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900_REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ACVIE (OFUNCTY SYNDrome day Medical resulting in death) Due to (or as a consequence of): Examiner Heart Years Athero Scierotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Enverse Director: After this certificate has been signed by the attending physician and erely filled in by the funeral director, page 2 should be detached for use es the burlar-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav ☐ Yes 2 ☐ No 9 I Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PULMONALY Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 2 ☑ No Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 [] 3 [] Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 16 2012 November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAL HOSPITAL OF BALTIMORE MO SOLNIN

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

. Registrar's Sign

12-08379 Francis Norris Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Tarrolo Morrio	1- For State Certificate of Death Registrar	Reg. No.	3/3/9	
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date Mont	of Death th Day Year ember 5, 2012	3. Time of Death 1130 hrs	
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2900 block Waterview Avenue Baltimore	4c. County of Death	1	
Funeral Director	217 02 9144 1X M 2 F 40 Yrs. Months Days Hours Min.	te of Birth (MM/DD/YYYY) 9. Birth		
OW ADY	Usual Residence of Decedent 10a. State		10d. Inside City Limits 1 Yes 2 X No	
th the Maryland 23a or 28a-f sho cotified at coce.	10e. Street and Number 10f. Zip Code 205 B 6th Avenue 21225	10g. Citizen of What Cour	ntry?	
er death wi	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 Yes 2 X No specify:	etc.) White, etc.	ican Indian, Black,	
5-0036 sd within 72 hours afti tygiene. other thao "natural" be Medical Examice Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter Carpenter	e 16b. Kind of Business/	-	
21215-0036 uld be filed within 72 hou Mental Hygiene. marked other thao "nat c evect, the Medical Exa To Be Completed		Middle, Maiden Surname) Arrington		
MD 21 d 2 should if the and Mer m 27 is man aumatic ev	19a. Informant's Name/Relationship (Type, Print)19b. Mailing Address (Street and Number or Rural RoJames Norris / Brother205 B 6th AvenueBal	timore, Maryla	nd 21225	
Baltimore, M permit. Pages 1 and 2 Department of Health. Important: If item 2 iojury or other traum	1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Bayview Crematory 11/13/2	Date 20c. Location - City or Town, St. /13/2012 Baltimore, Ma once Funeral Service, P		
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respira failure. List only one cause on each line.	Baltimore, Man		
Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascu Due to (or as a consequence of):	lar Disease	Death	
ted State of the s	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to for as a consequence of processor of the consequence			
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Division of Vital Records, P.O. Box 68760, To the Hospital or Atteodiog Physiciao: The law requires that the death certificate be executed within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transledical Certification: To Be Completed by Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 2 No 9 Unknown 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown 9 Unknown	23d. Date of deliver Month	y Day Year	
P.O. E res that the signed by the be detached by the by the bed detached by the by the by Ph	1	e. Did tobacco use contribute to		
Division of Vital Records, P.O. Box 687 rat or Atteodog Physiciae: The law requires that the death certificate rather death. **I Director: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the refification: To Be Completed by Physician/I	1	autopsy prior to death? ✓ Yes 2 No 1 ✓ Y	utopsy findings available completion of cause of es 2 No	
of Vitaliog Physiciae: After this certioneral director	25. Was case referred to medical examiner? 1 Yes 2 No 1 No 1 No 1 No		er; Scene	
Division of N To the Hospital or Atteoding Ph within 24 hours after death. To the Fuoeral Director: After it completely filled in by the funeral lectical Certification: T	Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 1 Specify) Natural 5 Pending Investigation 1 Yes 2 No 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. or (Specify)	ocation (Street and Number or Ri Town, State)	ural Route Number, City	
To the Hospit within 24 hour To the Fuoers completely fill Medical Ce				
	29b Signature and title of certifier 29c License number O.C.M.E.	29d. Date signed (Mo November 6, 20		
ϕ	30. Name and address of person who completed gades of death (fem 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	ore, MD 21223		
State Registra				

Neale Reginal Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death

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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours are used To the Funeral Director: After this certificate has been signed by the attending physician and commission in the funeral director page 2 should be detached for use as the burial-transit.
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	Please Type of State					All Copies Mental Hyg		gible.		
	State Registrar	- Trial y lair		tificate of D			Reg. No. 2	112,3732		
an/ ical	1. Decedent's Name (First, Middle, Last) Regina	С.	Nea			2. Date of Dea Month	Day 15 a	Year 7.55 P		
ner	4a. Facility Name (if not institution, give street and nu			4b. City, Town, or Rossv		ath	4c. County of Death Baltimore Co.			
	5. Social Security Number 6. Sex 7. A		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Min	n. (Month, Day	(Year)	9. Birthplace (State or Foreig Country)		
7	Usual Residence of Decedent 10a. State 10b. County		, Town or Lo	cation Dund		July 8,	, 1925	New Jersey 10d. Inside City Limit		
Director	MD Baltimore 10e. Street and Number		1 ☐ Yes 2 No							
Funeral	1928 Ewald Avenue	edent Ever in U.S	112 1	21222 Vas Decedent of Hi		Specify Yes or No-		nited States 14. Race - American Indian,		
<u> </u> 출	Armed F	orces? 2 XNo ive	'	f Yes, specify Cuba	n, Mexican, Pue	rto Rican, etc.)		ack, White, etc.		
Completed	15. Decedent's Education (Specify only highest grade complete		(Give	dent's Usual Occup kind of work done o O NOT use retired)		orking	16b. Kind of E	Kind of Business/Industry		
Be Co	12 Years 17. Father's Name (First, Middle, Last)	. , , , ,	Man	ager	18 Mother's N	lame (First, Middle,		Snack Bar		
힏	l ' ' ' '	Leston				Ida Norı				
	19a. Informant's Name/Relationship (Type, Print) Mr. Millard F. Neale,	Husband Jr.	1	-		Rural Route Number		State, Zip Code) 21222		
	20a. Method of Disposition	20b. P	lace of Dispo	EWAIG AV sition (Name of natory or other place		dalk, Man		- City or Town, State		
	1 Burial 2X Cremation 3 Removal from 4 Donation 5 Other (Specify)	Hil:	ltop S	ervice Co	orp. 11	/19/2012		n, Maryland		
	21. Signature / Funeral Service Licensee Gr	y F. Re	eed 8			. Home of Oundalk, N				
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	for as a consequence (or as a consequence) (or as a consequence)	ience of):	nding thora	cicart	a with hemo	rch age	Onset and Death		
Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, o 1 ☐ Liv 9 ☐ Un		1	Date of delivery Month Day Year						
þ	Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I.									
Completed	24a. Was an autopsy prior to condeath? 1									
To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital:	¶npatient 2 □	ER/Outpatio	Oth	er:	heck only one) Home 5 Resid	tanca 6 🗆 Ot	thar (Spaciful		
Certificate: T	27. Manner of Death 1 Natural 5 Pending (Mc) 2 Accident Investigation	e of injury enth, Day, Year)	28b. Time o injury	28c. Injur work	y at	28d. Describe h				
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined buil		eet, factory, office			ocation (Street and Number or Rural Route Number, ity or Town, State)				
Medical	29a. Certifier (Check 2 Medical Examiner: On the bonly one) 3 Certifying Nurse Practition	asis of examination	n and/or inves	tigation, in my opinion, death occurred at	on, death occurre the time, date an	ed at the time, date a	and place, and d the cause(s) and	lue to the cause(s) and manner st manner as stated.		
	29b. Signature and title of certifier			29c. Licens				5 - 2012		
tate trar	30. Name and address of berson who completed ca		000 F	anthin	Square	Drive Bo	altimo	12 mp 21237		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			a For	aryland /	•		lealth and M	lental Hyg	iene		2 - 2 - 2 - 1
			State Registrar		Cer	tificate of E	Death	R	eg. No. 🧷 📗	112	3/321
	Physicia		1. Decedent's Name (First, Middle, Last) Antoinette Helen		Nε	ey.		2. Date of Deat Month 11	Day	2012	3. Time of Death 10:33A M
	Medio Examin		4a. Facility Name (if not institution, give street and number)				Location of Death		Т	ty of Death	10.3311
	Z		47 Quarter Staff Place			Ве	rlin			Worce	ster
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 1 M 2 X F	e (In yrs. last bi 75	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 05/20/		9. Birthpl Count	lace (State or Foreign ry) MD
	d ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov				03/20/	.,,,,	1	
	arylan a-f sh fied a	ecto	MD Worcester	Toc. City, To		lin					0d. Inside City Limits 1 Yes 2 X No
	the Mi or 28 e noti	Funeral Director	10e. Street and Number			10f. Zip Code	-		l0g. Citizen of	What Count	try?
	s 23a	era	47 Quarter Staff Place			218	11			U.S.A	
	death item		11. Marital Status 1 Never Married 2 Married 12. Was Decedent E Armed Forces? 1 Yes 2 X	ver in U.S.	13. V	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)		ce - America	
336	s after al", on Exami	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates.	No	1	☐ Yes 2 🎇 No	Specify:		Specif		ite
<u>ج</u>	hour:	olete	15. Decedent's Education (Specify only highest grade completed)	16		ent's Usual Occupa	ation Juring most of worki	T.	16b. Kind of E	Business Ind	ustry
121	thin 72 nne. than '	Completed	Elementary/Seconday (0-12) College (1-4 or 5	+)	life. DC	NOT use retired)	_	'g	1	Real E	state
2	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Be	12 17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, N			
ylan	age 1 and 2 should be file ent of Health and Mental F nt: If item 27 is marked o' y or other traumatic ever	욘	Anthony Joseph	Ena			Agatha	Ma	ry	Santo	ni
Maryland 21215-0036	2 shou th and ?7 is m traum		19a. Informant's Name/Relationship (Type, Print) Mrs. Tina Eiser / Daughter	19		g Address (Street a	and Number or Rura	Route Number, n Burni	-		ode)
re,	f Healt f Healt item 2 other		20a. Method of Disposition		of Dispos	sition (Name of			20c. Location		wn, State
Ē	Page Trent o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			ss Cemet	ery 11/19	/2012	Glen	Burni	e, MD
Baltimore,	permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Service Licensee MO1479								Burnie, MD
	40 = 60		23a. Part 1. Enter the disease, or complications that caused	he death. Do			Funeral			ervice	Approximate
باستر	Physician		shock, or heart failure. List only one cause on each line Immediate Cause (Final	0/-1	1:	/	O .				Interval Between Onset and Death
	Medical	8 1	disease or condition resulting in death) a. Due to (or as a	consequence	e of):	2 mg	Des				
	Examiner	e	Sequentially list conditions, b.		0.						
	ted nsit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury								
	be executed sician and burial-transi	Ex	that initiated events resulting in death) Last C. Due to (or as a	consequence	e of):						
20	ate be ohysicii the bu	dical	d								
200	ding page as	n/Me	IF FEMALE: 23c. If yes, outcome of						23d D	ate of delive	n/
X PO PO	death c e atter d for u	Physician/Me	in the past 12 months? 1 Yes 2 No 4 Pregnant at			Ectopic pregnance Other (specify)	У	N 40			Day Year
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ν, Γ.	res tha signed	þ	Part II. Other significant containing to death of	at not resulting	g iii die di	idenying cause giv	enin Farti.	1 239. Did tot			e cause of death?
ord G	requi	lete						24a. Was ar		Were autop	sy findings available
Records,	The lav	Completed						autops perform	ned?	death?	pletion of cause of
Vital	cian: ertifica ector, p	Be (25. Was case referred to medical examiner?				ace of Death (Check				
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n or	nding th. : After e funer	cate	1 Natural 5 Pending (Month, Day, 2 Accident Investigation		injury	28c. înjury work' M 1 🗆	Yes 2 No	8d. Describe ho	w injury occur	rea	
UIVISION	r Atter er dea rector by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injurbuilding, etc.		farm, stre	et, factory, office		28f, Location (Str City or Town		ber or Rural f	Route Number,
ź	oital o										
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of r 2 Medical Examiner: On the basis of ex 3 Certifying Nurse Practioner: To the b	camination and	or investi	gation, in my opinio	n, death occurred at	the time, date an	d place, and du	ue to the caus	se(s) and manner stated.
_	To th within To th comp	~	29b. Signature and title of certifier	. ^		29c. License			9d. Date signe	ed (Month, D	
	11		AND SOLL	MU		02	6278		11-14	-14	
	1		30. Name and address of person who completed cause of de	ath (Item 23a) ו ארוש אי	(Type, Pr	rint) ROV 122	23 Sn/	65 L-	11/	218	72
	Stat			r's Signature	7		10 020	()	m	0.70	
	Registra	ır	NOV 2 0 2012 December 1	v 3.	100	We			_		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 18: 20 PM Jovembe Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Social Security Number If Under 1 Year If Under 7. Age In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 161-60-8061 Director 1 □ M 2 🗓 F 39 June 16, 1973 Pennsylvania al Hygiene. I other than "natural", or Items 23a or 28a-f show vent, the Medical Examiner must be notified at State 10h County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director West Norrinton Township 1 Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19403 813 Treetop Lane United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 24 Married δ 1 ☐ Yes 2 🗓 No Maryland 21215-0036 1 Yes 2 No Specify: WHITE If Yes. Give 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 4 College (1-4 or 5+) Elementary/Secondary (0-12) Healthcare Forms Procurement Be 17. Father's Name (First, Middle, Last) permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 Is marked ott any Injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) Eugene J. Kieczkajlo Cathy Welch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Troy R. Newell - HUSBAND 813 Treetop Lane, Norristown, PA 19403 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Stroudsburg, PA 18360 H.G. Smith Crematory 11-23-2012 4 ☐ Donation 5 ☐ Other (Specify) 5305 Harford Road Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PULMONARY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day the s 9 Unknown ed by t detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be det 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 🛂 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t director, page 2 s autopsy performed? Yes 2 No 2 🗆 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print); Zathmore Bo Kim 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ØHMH 17 Rev 06-2011

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State of Manyland / Department of Health and Mental Hygiene

iizabetii O i lea		1- For State Registrar	ate of Maryland		tificate of		u Menta		eg. No.	2017	2 3732
Physicia Medical Exami		1. Decedent's Name (First, Middle Elizabeth O'He						2. Date of Dea Month Novembe		Year	3. Time of Death 0818 hrs
		4a. Facility Name (if not institution				4b. City, Town, or	Location of D			ounty of Death	
	John Hopkins Hospital Baltimore n/a										
Funeral Director	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$								Foreign		
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locat	ion	-		_		10d. Inside City Limits
Aaryland 28a-f show 1 at nnec.	o	Maryland n/a		Balti	lmore						1 X Yes 2 No
th the Maryland 23a nr 28a-f she notified at nnee	Director	10e. Street and Number	- 4 17-24-44	1		10f. Zip Code			111	of What Coun	try?
		2327 Boston St 11. Marital Status	12. Was Decedent		S. 13. Wa	21224 as Decedent of His	spanic Origina	? (Specify Yes or No	USA - 14.	. Race - Americ	an Indian, Black,
r death w or items must be	Funeral	1 X Never Married 2 Ma	1 Yes 2	No		es, specify Cubar		uerto Rican, etc.)		White, etc.	
ırs afte lural", ıminer	δ	3 Widowed 4 Dive	orced If Yes, Give Yeer or Dates: cify only highest grade com	npleted)		Yes 2 X No		d of work done		e <i>cify:</i> Whit d of Business/Ir	
5 72 hou ral Exa	ompleted	Elementary/Secondary (0-12)	College (1-4 or			nost of working life				ns Hopk:	•
within spiene.	dwo	17. Father's Name (First, Middle,	5+		Profes	sor of N		<u> </u>		versity	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury nr other traumatic event, the Medical Examiner.	BeC	William O'Hearn	•				Elizab	Name (First, Middle, I Deth Tier		name)	
21 hould be and Mer is man	욘	19a. Informant's Name/Relationsh			19b. Mailing	g Address (Stree	et and Numbe	r or Rural Route Nur	nber, City o	or Town, State,	Zip Code)
and 2 sho ealth and 2 cm 27 is		Elizabeth O'Hea 20a. Method of Disposition	rn / mother	20b. P		East Des		rive Tucs		izona (
ages 1 a tof H		1 Burial 2 X Cremation		ate c	rematory or ot	her place)			1		,
Baltimore, permit. Pages I as Department of Hec Important: If ite		4 Donation 5 Other Sp 21 Signature of Juneral Service	ecify: Licenses tenbenie	Metr	o Crem	natory, In Name and Address		2/20/2012			
		Mach !			- 29	9 Freder	ick Ro	remation Sox ad Baltim	ore,M	laryland	
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.						est, shock,	or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse			ву нурос	nermia				- Joan
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K 68760, h certificate be ex- cending physician use as the burial	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	e 23c. If yes, outcor	ne of pregn		etal death 3	Ectopic pr	ecnancy		ate of delivery	ay Year
OX 687 ath certifica	sician/	past 12 months? 1 Yes 2 No 9 V Unki	4 Pregnant at	time of dea	=	ther (Specify)		egriancy	IVIO	711d1 D	ау төаг
D. Bo. t the deat by the at	Physic	Part II. Other significant condition	9 OHRIOWII	n but not re	sulting in the i	inderlying cause o	iven in Part I	23e Did to	obacco use	contribute to t	he cause of death?
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	þ		(()				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-			ably 4 Unknown
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could	28e. Place of In	jury - At ho		et, factory, office b	ouilding, etc.	28f. Location (or Town, S	Street and I	Number or Run	Boston St.
Di Tn the Hospital within 24 hours a To the Funeral I		29a. Certifier	mined (Specify) In			rred at the time. do	ate and place	Baltimo	re,MD	•	
in the lathin 2 the lather lathin 2 on the lather l	Medical		niner:On the basis of examination and manner stated.								
FSFO	ž	29b. Signature and title of certifier		(/	29c. Licens				e signed (Mon.	
		30. Name and address of person	1 1 1		220)	O.C.	IVI. ∟ .		Novem	nber 16, 20	12
			wno completed cause of d Assistant Medical Ex		,	Baltimore Stre	et, Baltimo	ore, MD 21223			
St Regist		31. Date filed (Month, Day, Year)	2012 32. Registra	r's Signatur	1. ba	Mad					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Owens iana 2012 Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimor Jorthwest Kandallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 214-44-1542 **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at by Funeral Director or 28a-f MD Baltimore Randallstown 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Hobart Court 21133 USA Page 1 and 2 should be filed within 72 hours after death with 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give African-American 3 ♥ Widowed 4 □ Divorced Completed Year or Dates and Mental Hygiene.
is marked other than "natural aumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Anne Arundel County Elementary/Seconday (0-12) College (1-4 or 5+) 12th Public Schools Oustodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Joseph Truesdale Gwendolyn Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Bernadette Kaufman/Daughter 3 Hobert Ct., Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 11-23-12 Pikesville, MD 22. Name and Address of Facility Wile Funeral Home P.A. of Baltimore Co. 9200 Liberty Rd., Randallstown, MD 21133 rt 1. Enter the disea complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate shock, or heart failure. Onset and Death Immediate Cause (Final Physician/ DAVOID rthero sclerotic disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Das to (or as a consequence or, use as the burial-tran resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy jo in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death detached 9 Unknow P.O. ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital Other: 1 Tes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural 5 🗀 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral D Medical LKCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title

Registrar

DHMH 17 Rev 7/2009

State

on who completed cause of death (Item 23a) (Type, Print)

Dionne J Smith Northwest Hospital

D00 63918

5401 01d Court Rd Balto ,MD 21133

16,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# 200, per FH, G934, 12/13/2012, wS

State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 O'Connor Martha Sue <u>07:4</u>0 A ^M November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 704 Radnor Court Anne Arundel Co. Glen Burnie Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Director 407-40-9017 1 □ M 2 🗓 F 78 10/24/1934 Kentucky Usual Residence of Decedent 28a-f show aţ 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director notified MD Anne Arundel Co Glen Burnie 1 Yes 2 X No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a death with 704 Radnor Court 21061 United States items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status "natural", or iter dical Examiner 14. Race - American Indian. Black, White, etc. or. þ 1 Never Married 2 Married 1 Yes 2 X No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced White Completed Year or Dates d Mental riversimmerked other than "natural marked other than "natural madical" 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Mean injury or other traumatic event. **Healthcare** Nurse 4 yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ္ Charles Η. Jenkins Della Jackson 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Denis C. O'Connor Son 8120 Buttercup Lane East, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12/14/2012 4 Donation 5 Other (Specify) Arlington Nat. Cem. Arlington, 21. Signature of Funeral S 22. Name and Address of Facility Singleton Funeral & Cremation MA Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ -or man disease or condition resulting in death) ears Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury consequence of): and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the a 9 Unknown 9 Unknown been signed by ti should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy 1 Yes 2 No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral Manner of Death 28b. Time of 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 1X Natural 5 Pending iniury 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 20a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and ti 29c, License number 29d, Date signed (Month, Day, Year)

within 24 hours a

GIEN BURNIE MD 20061

30. Name and address of person who coneted cause of death (Item 23a) (Type, Print)

SAMA M.

600 CRAIDH

State

101

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Louis Potler 2012 8:00 P November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3923 Norrisville Road Jarrettsville Harford If Under 1 Year I If Under 24 Hrs Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 212-28-9881 **Director** 80 1 🛛 M 2 🗆 F Baltimore, Maryland June 27, 1932 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f Maryland Harford Jarrettsville 1 Yes 2 XNo or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3923 Norrisville Road 21084 United States items n "natural", or item ledical Examiner m 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 27 is marked other than "natur r traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) General Contractor Potler Construction Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Paul Potler Sophie Zakrzeinske 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084Patricia Potler (Spouse) 3923 Norrisville Road Jarrettsville, Maryland Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place, Dulaney Valley Manorial Gardens 1 🏋 Burial 2 □ Cremation 3 □ Removal from State November 21, Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Name and Address of Facility Evans Funeral Chapel & Cremation Services—Bel Air 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter to shock, or hear complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a cons Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequen as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending Id be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performe 1 Yes 2 No 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 🗌 Yes ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatura and title of certifier a

Registrar

State

ROAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Passapae, Agnes:11/14/12- 12:15 Am laryland 21215-0036

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		Division of Vital Records, P.O. Box 68760		Baltimore, Maryland
)	To the Hospital or Attending Physicien: The law requires that the deeth certificate be executed	Ping , I Ex	permit. Pege 1 and 2 should be filed v
İ	1	within 24 hours offer death.	y s VI	Depertment of Health and Mental Hyg
)	To the Funerel Director: After this certificate has been signed by the ettending physicien end	ic ec m	Importent: If Item 27 is merked other
Ş	J	completely filled in by the funerel director, page 2 should be deteched for use as the burlel-transit	ia lic	eny injury or other treumetic event,
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	4	Please	State of N		d / Depa	rtment of H	lealth a		tal Hygi	ene	12	37327		
		Registrar 1. Decedent's Name (First, Middle, Last)			tificate of D	eaur		ate of Death	g. No.		3. Time of Death		
Physician Medic			Agnes		Passa			No	Nonth	1	Year 2012	12:15A ^M		
Examine	er	4a. Facility Name (if not institution, give s Oak Crest Care (4b. City, Town, or Parkvi		Death		4c. County	of Death timor	-e		
Funeral		5. Social Security Number 6. Se		ige (In yrs. la	ast birthday)	If Under 1 Year	If Under 24		ate of Birth		9. Birthpl	ace (State or Foreign		
Director			□ м 2 🔀 F	90	Yrs.	Months Days	Hours		Month, Day, Y	3,1922	Marv	land		
nd how	۱	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation			-P	,,		d. Inside City Limits		
Aaryla 8a-f e	ect	MD Baltimore					Parkv	ille				1 ☐ Yes 2🛣 No		
vith the Maryland 23e or 28e-f ehow st be notified at	Funeral Director	10e. Street and Number				10f. Zip Code			1	g. Citizen of V				
th with	iner	8820 Walther Blvd	01	21234 Vas Decedent of His	in? (Specify V		Jnited 14.500							
or Items	by F	11. Marital Status 1 ☐ Never Married 2 ☐ Married		Yes, specify Cubar	n, Mexican,	Puerto Rican	ican, etc.) Black, White, etc.							
2 hours eft "neturel", dical Exa	ted	3 ☑ Widowed 4 ☐ Divorced	1 Yes 2y If Yes, Give Year or Dates			☐ Yes 2x No	Specify:			Specify.	Whi	ite		
filed within 72 hours efter death with the Maryland ef Hygiene. d other then "neturel", or Items 23e or 28e-f eho veert, the Medical Examines must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	lent's Usual Occupa kind of work done d O NOT use retired)	ation Juring most o	of working	100 1	6b. Kind of B	usiness/Ind	ustry		
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uld be t Ment merke	۵	Edward Chabot	D (-1)		T			hristi				- 4-1		
12 sho lith end 27 Is r		19a. Informant's Name/Relationship (Ty Janet Passapae-Sau		hter)		ng Address (Street a Knox Ave		isters			136	ode)		
of Hee		20a. Method of Disposition	Daniel from Cha		Place of Dispo	sition (Name of natory or other plac	e)	Date	2	Oc. Location	- City or To	wn, State		
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permit. Pege 1 and 2 should be filed within 72 Depertment of Heelth end Mentel Hygiene. Importent: If Item 27 is merked other then eny injury or other treumetic event. Item Megone.		21. Signifure Funeral Arvice Licens	angle			Name and Address Duda – Ruc 7922 Wis	se Ave	. Dund	lalk, l	Marylar				
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death		
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n #	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying												
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Atten er deat ector: by the	Ě	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	ome, farm, st	reet, factory, office			28f. Location (Street and Number or Rural Route Number,							
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To the Hospital or Attending Physiclen: The law requires thet the deeth certificete by within 24 hours effer death. Within 24 hours effer death. To the Funerel Director: Affer this certificete has been signed by the ettending physicompletely filled in by the funerel director, pege 2 should be deteched for use as the tompletely filled in by the funerel director, pege 2 should be deteched for use as the tompletely filled in by the funerel director.	Medical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										use(s) and manner stated.		
~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~		29b. Signature and title of certifier Tickealle 3/1		NE M		29c. Licens			25	9d. Date signe	ed (Month, l	Day, Year)		
7 Ph		30. Name and address of person who	completed cause of	of death (Iter	Park R171944 11/14/2012 Jeath (Item 23a) (Type, Print) 8800 Wolfher Blvd Parkwelle MD 2/234 ar's Signature. B. Farking									
Sta		31. Date filed (Month, Day, Year)	32. Regi	strar's Signa	ature.	1	4 /(0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
Registr		NUV 2 0 2012	Gerena	p. /	year	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JAMES MARLYN PATE Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 7. Age (li **Funeral** Days Months Hours 81 299-26-2172 1 M 2 □ F Director /5/1931 TX Usual Residence of Decedent Itam 27 is marked other than "nature!", or itams 23a or 28a-f show other traumatic event, the Medical Exeminar must be notified at 10d. Inside City Limits 10c. City, Town or Location death with the Meryland Director 1X Yes 2 ☐ No BALTIMORE MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 USA 817 S. GRUNDY STREET 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married δ filad within 72 hours efter 21215-0036 1 ☐ Yes 2 🔀 No Specify. WHITE If Yes Give Specify. Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 Elementary/Secondary (0-12) al Hyglane. College (1-4 or 5+) BALTIMORE CITY POLICE OFFICER Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o VERSIE ACORD HAROLD PATE Page 1 end 2 should be permit. Page 1 and 2 should Department of Health and M Important: If Itam 27 is mar any Injury or othar traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 S. GRUNDY STREET BALTIMORE, MD 21224 ARLENE PATE-WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State DAKLAWN CEMETERY 11/20/12 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER AND SON of Funeral Carvice Licenses . Signatu BALTIMORE, MD 21224 6224 EASTERN AVE 234. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or fleart/failure. List only one cause on each line. Approximate Interval Between Onset and Death Pnysician disease or condition Medical resulting in death) Examiner On Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequ Exami Hospital or Attanding Physician: The lew requires that the death certificate be axecuted inding physician and usa as the burial-tran Due to (or as a consequence of): resulting in death) Last ettending physician for usa as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 24 hours after death.

• Funeral Director. After this certificate hes been signed by the eletely filled in by the funeral director, page 2 should be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: Natural
Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Funer completely fil 29a. Certifier (Check only one) License number 00 Franklin Squar

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 20

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	St	ate of Ma	ryland /	Departmer Certificat			d Mental Hy	giene Reg. No.2	112	37329		
	Physicia		Decedent's Name (First, Clara ANN							2. Date of De Month	ath ER 14,2	Year	3. Time of Death 11:20P M		
	Medic Examin		4a. Facility Name (if not ins		and number)		4b. City	, Town, or L	ocation of D			y of Death	11:20F		
			OAK CREST	VILLAGE (CARE CEN	TER		PARKV				BALTO			
	Funeral Director		5. Social Security Number 273-44-6042 Usual Residence of Dece	,	_	(In yrs. last bli 92	Months Yrs.	Days	Hours N	8. Date of Bir (Month, Da 2–6–1	y, Year)	9. Birthp Coun OHIO			
1	rland f show d at	tor		County		10c. City, Tov	vn or Location					1	0d. Inside City Limits		
	r 28a-	Director	MD. 10e. Street and Number R	BALTO.	CE CARDE	การ	PARKV	D Code			10g. Citizen of	What Cour	1 🗆 Yes 2 🛣 No		
3	with th 23a o ist be		8832 WALTHER		CE GARDI	2MD	101.21		234			SA	itry:		
) Maryland 21215-0036	I and 2 should be filed within 72 hours after death with the Maryland if Heath and Mental Hygiene. If Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	eted by Funeral	11. Marital Status 1 Never Married 2 3 X Widowed 4 Di	☐ Married 1	das Decedent Evermed Forces? Yes 2 XN Yes, Give ear or Dates.	0	13. Was Dece If Yes, spe 1 Yes	cify Cuban	Specify:	(Specify Yes or No- uerto Rican, etc.)			etc. [ITE		
1215	within 72 h giene. ier than "na ;, the Medic	Completed	(Specify on Elementary/Secondary	ly highest grade cor			(Give kind of wo	rk done du	ring most of	working		HOME	dustry		
d 2	filed wit al Hygie d other vent, th	a	12 17. Father's Name (First, M	fiddle, Last)	4		поп			Name (First, Middle,	<u> </u>				
ylan	ld be fi Mental iarked atic ev	2	LEWIS D. JENNINGS						LOIS	W. NELSON	Γ				
Mar	2 shou th and 7 is m traum:	1	19a, Informant's Name/Re			1	b. Mailing Addres			Rural Route Numbe	r, City or Town,		Code)		
ξ. j.	of Healt of Healt fitem 2 r other		THOMAS C. I 20a. Method of Disposition	1		20b. Place	of Disposition (Na	me of		Date	20c. Location		own, State		
Similar S	Ψ = 0		1 X Burial 2 Crei	Other (Specify)	val from State		ery, crematory or MEMORIAL		i .	1-19-2012					
Balt	permit. Pag Department Important: any injury once.		21. Signature of Fureral S	Cou	9			5 BEL	AIR RO	AD NOTT	NGHAM,		ME, INC. 21236		
7)	nysician/ .		23a. Part 1. Enter the dise shock, or hear failur Immediate Cause (Final	e. List only one cau	se on each line.			•	, such as card	diac or respiratory ar	rest,		Approximate Interval Between Onset and Death		
4	Medical Examiner		disease or condition resulting in death)	a	Due to (or as a		on: Disect					1			
77		iner	Sequentially list condition if any, leading to immedia cauco. Enter Underlying	s, b. —	Due to (or as a	consequence	of):						<u> </u>		
	e be executed ysician and te burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):												
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6876	ing ph	/Mec	IF FEMALE:	00.4		,				<u></u>		1			
++e C Box 6876	requires that the deam cermicater been signed by the attending phys should be detached for use as the	Physician/Med	23b. Was decedent pregnatin the past 12 months 1 Yes 2 Vo 9 Unknown	5? 1	yes, outcome of Live Birth 2 Pregnant at t Unknown	Fetal dea	th 3 Ectopic 5 Other (s	pregnancy pecify)			l l	ate of deliving	ery Day Year		
3.	es tnat t signed b	d by P	Part II. Other significant conditions contributing to death but not resulting in the under Dementio						en in Part I.				ne cause of death?		
Sce Annual Seconds	been should	Completed by	24a. Was an 24b. Were autopsy fin										psy findings available		
Sec.	ine iav ate has page 2	Som								— auto perfo 1 ☐ Yes	psy prmed? 2 No	death?	mpletion of cause of		
tal tal	cran: sertifici ector,	Be	25. Was case referred to mexaminer?	nedical Hospit	al:			26. Pla		Check only one)					
β _₹ }	this c	2:	1 Yes 2 No		1 Inpatier		Outpatient 3 Time of	28c. Injury	4 Nursir	ng Home 5 Resi	dence 6 COt				
2 ou o	Attending Physician: The law ar death. ector: After this certificate has by the funeral director, page 2 s.	icate	1 Natural 5 🗆 2 🗀 Accident	Pending Investigation	(Month, Day,		injury M	work?	res 2□No	I	ion injury cood	100			
	ਰ <u>ਵੱ</u> ਛੋਂ ⊆	Il Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)							28f. Location (City or Tou		ber or Rura	l Route Number,		
	ne Hospital in 24 hours a ne Funeral I pletely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occur. 2 Medical Examiner: On the basis of examination and/or investigated and the basis of examination and/or investigated and the basis of my knowledge, death occur.						n, death occur	and place, and d	ue to the ca	use(s) and manner stated.			
	Io the within 2 To the comple		29b. Signature Med title of	to fair to	THE MISH			number 144		29d. Date signed (Month, Day, Year)					
20			30. Name and address of Micheolle Ho	person who comple	ted cause of dea	ath (Item 23a)	(Type, Print)	/ M	() 2/23	4	7.7				
	Stat Registra	e ar	31. Date 10 V 2 0 2	112 Sens	32. Registr	's Signature	es es	//			-				
DUM	H 17 Rev 06-2			-				-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 130 AM 2 rinar Jovember 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHU Baltimore HOSPITA The Johns Hopkins Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 🔀 M 2 🗆 F Director 216-92-9012 82 November 22, 1929 India Usual Residence of Decedent 28a-f show 10d. Inside City Limits aţ 10a. State 10b. County 10c. City, Town or Location Director notified 1 Yes 2 X No <u>Maryland</u> Gaithersburg Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ritems 23a or ner must be n ō Funeral 8239 Mountain Laurel Lane 20879 United States death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-"natural", or item edical Examiner r 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married þ Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: Asian Indian 3 Divorced 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry h and Mental Hygiene.
It is marked other than traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Civil Engineer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Gokalbhai Patel Laxmiben Patel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8239 Mountain Laurel Lane, Gaithersburg, MD 20879 Pushpaben Patel/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 18 1 \square Burial 2 $\cancel{\mathbf{x}}$ Cremation 3 \square Removal from State west Arundel 2012 Crematory Odenton, Maryland 4 Donation 5 Other (Specify 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 21. Signature of Fu MO1386 caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, Part 1. Enter shock, or hea Interval Between Onset and Death Immediate Cause (Final Phynician/ disease or condition neumonia Medical resulting in death) as a consequence Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Division of Vital Records, or Attending Physician: The law requires 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an s certificate has balirector, page 2 s autopsy performed? Yes 2 X No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ျှ 1 Depatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 1 Natural injury 5 Pending work?
1 Yes 2 No of Funeral Director: At bletely filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the F

complet 3 29b. Signature and title of certi-29c. License number 29d. Date signed (Month, Day, Year) RES-000 November 16, 2012

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Registrar

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31. Date file

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1800 Oneuns Street Balto mozizes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Director 244-88-4277 1 🗆 M 2 🔯 F 61 January 13, 1951 North Carolina 28a-f show an "natural", or items 23a or 28a-f sho Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2051 Orchard Avenue 20794 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired)
Program
Management Specialist 1 (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the University of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Hilda DeMent John Perkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 2051 Orchard Avenue, Jessup, Maryland 20794 Curtis K. Pruett/Husband Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date November Department of cemetery, crematory or other place. West Arundel Injury or 1 Burial 2 of Cremation 3 Removal from State Important: I any Injury o 4 Donation 5 Other (Specify) 2012 Odenton, Maryland Crematory Signature of Funeral Service Lidense Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 M01386 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ progression disease or condition resulting in death) Cancer Medical Due to (or as a consequence of): Examiner mucinous ovarian Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown signed by the a ld be detached f 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by cate has been sig Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform certificate Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital ည 1 N Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death . Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

KOSZTOWSKI

Maryland 21215-0036

Box 68760

P.O.

Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 1024AM come Vec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 213-68-9495 Director IXIX M 2 IF 58 6/18/1954 MARYLAND Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Extrainer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No ANNE ARUNDEL ARNOLD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 504 MOORINGS CIRCLE 21012 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ≥ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "na any injury or other traumatic event access." 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 2 YEARS ADVERTISING AGENT ADVERTISING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JEROME F. PIVEC ELEANOR DOHERTY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN A. PIVEC/WIFE 504 MOORINGS CIRCLE ARNOLD, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 7/20/2012 CATONSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityOHNSON-FOSBRINK FUNERAL HOME, P. A MO0217 LOCH RAVEN BLVD. TOWSON, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only pre-cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SQAMOU Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burlal-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Por in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 No signed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTERI 1 Ses 2 □ No 3 □ Probably 4 □ Unknown page 2 should peen 24a. Was an 24b. Were autopsy findings available After this certificate has autopsy prior to completion of cause of death?

1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital 2X No မ 1 Inpatient 2 FR/Outpatient 3 IDOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D2386

Queenstown

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2012 Fiorenza Baldi Pompa 10:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Queen Anne's Heartland House Queenstown 5. Social Security Number 8. Date of Birth (Month, Day, Year) 02/21/1926 Birthplace (State or Foreign Country)
 D.C. 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Director 1 - M 2 E F 578-28-3826 86 Usual Residence of Deced permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Queen Anne's Oueenstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3106 Bennett Point Road 21658 **USA** 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify. 3 Divorced 4 Divorced Completed Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Property Maneger Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Filippo Baldi Rosina Cerallo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Pompa / Daughter 4 Belvedere Court, Annapolis, MD 21403 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/19/2012 Chesapeake Crematory Beltsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall (Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) FUTRAL Fable Medical Due to (or as a consequence of): Examiner ARDIOMYODAT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine signed by the attending physician and defected for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit pertension that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pottypedita Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖲 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy yslim Herena 1 ☐ Yes 2 ☐ No Yes 2 No 25. W s cas referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\mathbb{\text{Residence}} \) Other (Specify), \(\text{CMRL Ity MR} \) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending **■**Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 🖲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number

Registrar

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and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

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23889

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 4:05 101 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign (Month, Day, Year) Hours 243-24-1960 Director 1 🗆 M 2 🖾 F fuly 9, 1923 Usual Residence of Decedent ital Hygiene. ad other then "naturel", or Items 23e or 28a-f show event, the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director NC Lenoir Kinston 1 Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1113 Patterson Road 28504 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2基 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced Black Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ge 1 and 2 should be filed nt of Health and Mental H :: If item 27 is marked ot မ Frederick White Sylvia Cobb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Courtney M. Patterson (Son) 1105 Patterson Road Kinston, NC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 of P Page 1 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Importent: If eny Injury or once, 4 Donation 5 Other (Specify) Patterson Cemetery 11-24-12 Kinston, NC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Metropolitan Funeral Service Vine Street Alexandria, of 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a con Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physicien: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Day Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? 1 Yes 2 No Yes 2 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 W M6 မ 1 Dinpatient 2 ER/Outpatient 3 DO/ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Division 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Dettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one 29b. Signature and title of certif 00 6 30. Name and address of person who completed clause of death (Item 23a) (Type, Print) HOWAR GORIN 31. Date filed (Month, Day, Year)
NOV 2 0 2012 32. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1, per phy, g933 11-20-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month Physician/ 0 626 AM PACHINO 16 2013 Erik Spencer Pachino Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shock N/Aof Maryland SAUTIMO126 nivusity TRAUMACE If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday **Funeral** Days Min (Month, Day, Year) **V** M 2 □ F Director 216-11-7658 26 02 1986 16 MD ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🙀 No MD BALTIMORE LUTHERVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 8 TUDOR COURT 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married by 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: "natural", 3 Widowed 4 Divorced Completed WHITE Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. WAITER CHEESECAKE FACTORY Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျှ HENRY RONALD PACHINO CYNTHIA KOLSCHER and 2 should be Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau WOODCOURT ROAD, BALTIMORE, MD RONALD HENRY PACHINO/FATHER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BETH TFILOH CONGR. 11/18/2012 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Nio SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN PIKESVILLE, ROAD, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARREST CARDIAC disease or condition Medical resulting in death) Examiner AORTIC INJURY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine EXAMINER MOTOR UEHICLE CRASH BERTIFICATION APPROVED BY MEDIT nding physician and use as the burial-tran that initiated events resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE: s, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death?
1 Yes 2 No Division of Vital Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 → patient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) Certificate: within 24 hours after death.

To the Funeral Director: After injury 5 Pending 1 Natural 2:04 AM 14 2012 2 Accident 3 Suicide Investigation UEHILLE CRASH MOTOR 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) YOVK ROOG OF FORM 4 Homicide determined street MD GBO4 TOWSON Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Chec only on 29b. Signa 29d. Date signed (Month, Day, Year) son who completed ca use of death (Item 23a) (Type, Print) TIMORE State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 16, Physician/ 2012 NOVEMBER 3:55 A M POTASH **ESTHER** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEDSTAR MONTGOMERY MEDICAL CENTER MONTGOMERY OLNEY Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year, Hours 578-50-0422 Director 1 □ M 2 🛚 F 03/03/1915 97 MD Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c, City, Town or Location Director 1 Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? Funeral 21208 11 SLADE AVENUE, UNIT 914 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces?
1 ☐ Yes 2X No Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: 3 X Widowed 4 □ Divorced WHITE Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) UNIVERSITY College (1-4 or 5+) 5+ Elementary/Secondary (0-12) **PROFESSOR** OF MARYLAND Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ REBECCA MANDEL 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SLADE AVENUE, UNIT 914, BALTIMORE, MD MICHAEL POTASH/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONGR. 11/18/2012 BALTIMORE, MD 21. Sign ture of Funeral Service Li 22. Name and Address of Facility SOL LEVINSON & BROS., INC. rechau 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death interction Immediate Cause (Final Myocardial Plusician/ disease or condition resulting in death) Medical Due to (or as \ onsequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records. the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Anen has autopsy death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 PNo ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation 24 hours after death Funeral Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) NOV 2 0 2012

Decelepre Konatchen, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

DE3747

KOUATCHOW, medster montgomery medical lenter, olney, mary land

29d. Date signed (Month, Day, Year)

Hovember, 16/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Nova Month Day 18:43 trances ZCIZ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memorial Union 12 Hospital 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months 246-38-6661 Director 1 □ M 2 🖾 F NC. 12-9-1924 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD timore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married Black White etc. 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates 3 🗌 Widowed 4 🗆 Divorced 16b. Kind of Business/Industry
HOUSING AUTHORITY 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Residents 10th Baltimore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fax trances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 Department of Health Important: If Item 27 any Injury or other tr once. Everall 20b. Place of Disposition (Name of cemetery, crematory or other pla 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Balto, MD 4 ☐ Donation '5 ☐ Other (Specify) 11/21/2012 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F. H. Avenue Balto, MA Drth 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Si Onset and Death Physician/ 2 disease or condition z4 hours Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-tran after death.

Director: After this certificate has been signed by the attending physician and in hw the funeral director, page 2 should be detached for use as the burlantra that initiated events Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 🗌 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation in my calculated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie AU4176435B102502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZOI East University Parkway Baltimore MD ZIZI8

DHMH 17 Rev 06-2011

State Registrar irkill

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Baltimore Randallstown 5. Social Security Number 212-42-6319 6. Sex Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Birthpiece. Country) MD Months Days Hours Min 11-8-1944 Director 1 X M 2 □ F 68 Yrs 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Windsor Mill 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 Funeral 3106 Northmont Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 Specify: African-American 1 ☐ Yes 2 X No Specify. If Yes, Give 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11th Carpentry Sorenson Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sidnev Rhue Sr. Minnie Brown permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other trauma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janie M. Rhue/Wife 3106 Northmont Rd., Windsor Mill, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 11-24-2012 Woodlawn, MD Wylie Funeral Rome P.A. of Balto. Co. 22. Name and Address of Facility 9200 Liberty Rd., Randallstown, MD 21133 Part 1. Enter the disease, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumon disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? . Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy s after death.

| Director: After this certificate 1 🗆 Yes_ 2 🗆 No 1 Tes Division of Vital filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 Hospital hos 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Mannet of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year,

DHMH 17 Rev 06-2011

State

Registrar

NOV 2 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 15, 2012 8:25 A Henry Thomas Rinehart 4a. Facility Name (if not institution, give street and number) 4c. County of Death Harford 4b. City, Town, or Location of Death 1820 Conowingo Road Apt. A Bel Air Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Min 212-76-7810 1 M 2 □ F 54 May 25, Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🔀 No Harford Bel Air Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 1820 Conowingo Road Apt. A USA 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Manufacturer Iron Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Lois Leonard Charles James Rinehart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1820 Conowingo Road, Apt. A, Bel Air, MD 21014 Terry Wagoner Rinehart / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State cemetery, crematory or other place 11-16-2012 Bel Air, Maryland Se Hill Sycs IIC

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.

Physician/

Medical

10a. State

Examiner

Funeral

Director

or 28a-f show notified at

must be 23a

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Director

Funeral

by

Completed

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician Medical Examiner

Examine Hospital or Attending Physician: The law requires that the death certificate be executed and attending physician I for use as the buria Physician/Medical the shed f ed by the à Completed cate has it, page 2 s certificate Be Medical Certificate: To n 24 hours after death.

Ne Funeral Director: Af pletely filled in by the fu

Division of Vital Records, P.O. Box 68760

	1050 11	TIT DVCD/ TILC	120		1
21. Signature of Funeral Service License	Much	22. Name and Address of Facility M 1317 Cokesbury R	McComas Fune Road, Abingd	ral Home on, Mary	, P.A. land 21009
23a. Part 1. Exter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not e cause in each line. a	s cell Carcin		routh	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No g Unknown	3c. If yes, outcome of pregnancy 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	livery Day Year
Part II. Other significant conditions con	tributing to death but not resulting in t	the underlying cause given in Part I.			the cause of death?
			24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of 2 4 No
25. Was case referred to medical examiner?		26. Place of Death (Ch	heck only one)		
1 Ves 2 No	ospital: 1	patient 3 DOA Other: 4 Nursing	Home 5 Residence	6 ☐ Other (Spec	ifv)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury 28b. Tim (Month, Day, Year) inju	ne of 28c. Injury at	28d. Describe how inj		
4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	, street, factory, office	28f. Location (Street a City or Town, Sta		ral Route Number,
(Check 2 L Medical Examine	er: On the basis of examination and/or in	eath occurred at the time, date and place nvestigation, in my opinion, death occurre edge, death occurred at the time, date and	ed at the time, date and place	ce, and due to the o	ause(s) and manner stated
29b. Signature and title of certifier	1 mr	29c. License number	9 7 7 29d. E	ate signed Month	, Daf, Year)

DHMH 17 Rev 06-2011

State Registrar

completely within 2.

	atte.	-	1 - For State of Maryland /		artment of tificate of	Health a		ental Hy		1 2	37340		
	Physicia Medio		1. Decedent's Name (First, Middle, Last) Cherie Ranson					2. Date of Dec Month 10/3	. Day	Year	3. Time of Death 10:10p M		
)	Examir	ner	4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last bi	intto day.	4b. City, Town, o Balt:	imore							
	Funeral Director		215-96-6061 Usual Residence of Decedent 1 □ M 2X F 43	Yrs.	Months Days		Min.	8. Date of Birt (Month, Date 0 3 / 2 0					
	Maryland 28e-f sho notifled at	Funeral Director	10a, State 10b. County 10c. City, Tov	wn or Loc Ba	ation	9				1	0d. Inside City Limits 1 Yes 2 □ No		
	th with the ns 23e or must be o	neral [2116 Tucker Lane Apt C1		10f. Zip Code 2120	7		- 1			try?		
-0036	permit. Pege 1 and 2 should e fried within 72 hr.drs after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inpartant: I frem 27 is marked other than "naturel", or items 23e or 28e-f show any Injury or other treumetic event, the Medical Extendent must be notified at once.	ğ	11. Marital Status 1X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Ves 2 No If Yes, Give Year or Dates.	1 1	Vas Decedent of I	an, Mexican, Specify:	in? (Spec , Puerto R	cify Yes or No- lican, etc.)	Bla Specify	nck, White, e Bla	ck		
Maryland 21215-0036	within 72 h /giene. ner than "n: t, the Medi	e Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give k	ent's Usual Occupind of work done NOT use retired abled	during most	of workin	g		Ac. County of Death 10:10p M 4c. County of Death 9. Birthplace (State or Foreign Country) Unk 10d. Inside City Limits 1X Yes 2 No Citizen of What Country? USA 14. Race - American Indian, Black, White, etc, Specify: Kind of Business/Industry Disabled an Surname) or Town, State, Zip Code) altimore MD 21207 Location - City or Town, State len Burnie MD Crem & Fun Serv Rd Hanover MD Approximate Interval Between Onset and Death Month Day Year 23d. Date of delivery Month Day Year 21db. Were autopsy findings available prior to completion of cause of death? 21db. Were autopsy findings available prior to completion of cause of death? 21db. Were autopsy findings available prior to completion of cause of death? 21db. Were autopsy findings available prior to completion of cause of death? 22db. Were autopsy findings available prior to completion of cause of death? 21db. Were autopsy findings available prior to completion of cause of death? 21db. Were autopsy findings available prior to completion of cause of death? 22db. Were autopsy findings available prior to completion of cause of death? 21db. Were autopsy findings available prior to completion of cause of death? 22db. Were autopsy findings available prior to completion of cause of death? 21db. Were autopsy findings available prior to completion of cause of death? 22db. Were autopsy findings available prior to completion of cause of death? 22db. Were autopsy findings available prior to completion of cause of death?			
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Baltimore,	ft. Pege 1 rtment of i rtant: If its njury or of		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atla	ery, crem anti	sition (Name of latory or other pla C Crem		11/5		Glen	Burn	ie MD		
Ba	Depa Impo any It		21. Signature of Fujeral Service Licensee	Т	homasAl	llenP	A 70	90 Ri	dge Rd				
	hysician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each lire. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence	Car	the mode of dying	. 1			ory		Interval Between Onset and Death		
- Political	and I-transit	ical Examiner	S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence consequence) c. Due to (or as a consequence definition of the consequence)	, 					-				
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JS, P.O	in signed build be deta	ed by P	Part II. Other significant conditions contributing to death but not resulting	in the un	nderfying cause gi	ven in Part I.		ļ					
Hecords,	ate has bee page 2 sho	Complet						24a. Was a autop perfor	sy męd?	prior to con death?	npletion of cause of		
Vital	his certific if director,	To Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O	utpatient	Oth	lace of Death er: 4 Nur		only one)			11		
ion of	leath. tor: After t the funere	Certificate:	A Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation 3 ☐ Stricte 6 ☐ Could not be	Time of injury		yat ⟨? Yes 2	- 1	3d. Describe ho	ow injury occurr	red			
DIVISION oital or Attendir	eral Directification by		4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
the Hos	ithin 24 ho b the Fun ompletely	Medical	29a. Certifier (Check only one) 29 Medical Examiner: On the basis of examination and/only one) 29b. Signature and title of certifier	or investig	nation in my onini	on, death occ the time, date	urred at th	he time, date ar e, and due to th	nd place, and du ne cause(s) and r	e to the cau nanner as st	se(s) and manner stated. ated.		
	I W		30. Name and address of person who completed gause of death (Item 29a)	/The D	DI	828	7		NOV Date signer	$\frac{1}{1}$, $\frac{1}{2}$)/2		
	Stat		31. Date filed (Month, Day, Year) 22. Registrar's Signature	Ton	Ave	Be	alto	MD	2/2	229			
	Registra		NOV 2 0 2012 June S. A	back									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nancy Reis 11/14/2012 Physician/ 2042 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Ctr Bel Air Harford ocial Security Number Birthplac Country) MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 218-48-3820 Hours 03/01/1948 Director 1 M 2 XF 64 or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Forest Hill Harford 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 423 Chestnut Hill Road USA 21050 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Was Deces? Armed Forces? □ Yes 2 X No Black, White, etc. ō by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White er than "natural", the Medical Exar Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72, and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Eichelberger Nina Buber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Reis Husband 423 Chestnut Hill Rd Forest Hill MD 21050 If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town. State ō 1 Burial 2 remation 3 Removal from State Atlantic Crem injury or Department Important: If any injury or 11/21/12 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of Fundinal Service Licensee. ThomasAllenPA 7090 Ridge Rd Hanover MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition ba Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any local good received accesses. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of burial-tra M800320401 Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 attending pl IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death ed by the at detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes မှ 1 Inpatient 2 NER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying these Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of com icense number 29d. Date signed (Month, Day, Year) 2012 30. Name and address of pern who completed cause of death (Item 23a) (Type, Print) 500 Upper Chase

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

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2042

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 18 P M Medical Mercedes C. Roberts 2012 3:05 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Harford Timonium Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) 12/26/1924 Director 1 □ M 2 1 F 218-18-7031 87 Maryland Yrs Usual Residence of Deceden ?7 is merked other then "neturel", or items 23e or 28e-f show traumetic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location Director 10d. Inside City Limits ¹X☐ Yes 2 ☐ No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1206 Vermont Road 21014 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 2 1 Never Married 2 Married end 2 should be filed within 72 hours after or Health and Mentel Hygiene. 1 ☐ Yes 2X☐ No 3 √ Widowed 4 □ Divorced Specify: Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Dietician Food Service Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ed Burns Catherine Fritz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William John Roberts / Son 311 Prior Road, Newport News, VA 23602 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 e Depertment of H 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/20/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Double Dorota Marshall < Shall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) LUNG CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use es the burlal-trensit that initiated events resulting in death) Last Due to (or as a consequence of) Certificate: To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 👿 No 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 A No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 No Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2**9**c. License number

State

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18,

NOVEMBER

Registrar

DHMH 17 Rev 06-2011

JACKIE JONES

NOV 2 0 2012

31. Date filed (Month, Day, Year,

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Saunders NOVEMBER 0250 AM lean 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Carroll Carroll Hospital Hospital Center Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 1 □ M 2 🗓 F (Month, Day, Year) Feb. 1, 1955 Days 214-66-9612 Director 57 MD Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Carroll MD Westminster 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21157 70 South Church Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. py 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Convenience Store Manager Grocery permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas William Carpenter Jean Kissler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 70 S. Church St., Westminster, MD 21157 Mr. Frank Saunders (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 11 County Cremation 11-18-12 Sykesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PROBABLE LUNG CANGER MASS disease or condition resulting in death) LUNG Medical Due to (or as a consequence of) Examiner OBSTRUCTIVE SLEEP APNEA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) FAILURE death certificate be executed ACUTE AND CHRONIC RESPIRATORY the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PAROXISMAL A-FLD, MORBID OBESITY, CHRONIC ANGULA, HYPOTHYROID 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an HYPERLIFIDEMIA, DIABETES TYPEZ, GASTROESCPHAGEAL REFLUX DISEASE performed? BIPOLAR DISCRDER 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 7 1 Inpatient 2 I ER/Outpatient 3 I DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 690896 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

3altimore.

Box 68760/

P.O.

Records,

Division of Vital

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 19 November 2012 Physician/ 07:15 PM Sullivan Rita Ann Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Pasadena Anne Arundel 253 Magothy Beach Road Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oct. 22 1927 PA 185-20-3787 1 🗆 M 2 🛛 F 85 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2 No Pasadena Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 253 Magothy Beach Road 21122 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 N Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Household Homemaker 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Theresa Lelli Thomas Annanie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 253 Magothy Beach Road, Pasadena, MD 21122 (daughter) Luanne McKenzie 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. Date 23 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MAryland Glen Haven Cemetery 2012 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Funeral Service Licenses 3111 Mountain Road, Pasadena, MD 21122 not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Par 1. Enter the disease, or complications that caused shock, or heart failure. List one one cause on each line. Onset and Death FIBIZILLATION Immediate Cause (Final IAL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner TENSION Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to for as a consequence of, Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month erel Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred e Hospital or Attending Pt 24 hours after death. e Funerel Director: After th Certificate: 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie R10 4338 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VETERANS HIGHWAY MILLYSVILLE MD Z1108 82. Registrar's Sign ture 31. Date filed (Month, Day, Year) State WOY 2 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:15 FM sero ine John Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSpita Sayare timore ranklin 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213 28 2488 05/26/1927 **Y** M 2 □ F Director 85 MARYLAND ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD BALTIMORE ROSEDALE 1 ☐ Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1218 HILLDALE ROAD 21237 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 → Yes 2 □ No Black, White, etc Completed by 1 Never Married 2 Married 21215-0036 Year or Dates. If Yes, Give 1 Yes 2 No Specify: Specify: WHITE "natural", 3

Widowed 4 □ Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) SUPERVISOR BETH STEEL Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ALPHONSE SCHAFER MARIE VILDT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE MINKLEY / DAUGHTER 1636 WALKER ROAD FREELAND, MARYLAND 21053 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/21/12 BALTIMORE, MD 4 ☐ Donation 5 🕱 Other (Specify) ENTOMEMENT GARDENS OF FATIH 21. Signature of Fundal Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Coronar Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician a detached for use as the burial-Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death ☐ Pregnant☐ Unknown 1 ☐ Yes ∠ ☐ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe this certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: မ 1 Tes 2 No 1 Inpatient 2 FR/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? ■ Natural 5 Pendina injury Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medica 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 11/19/12 00052243 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blumer Jacob 6. 10 N. (sreene 31. Date filed (Month, Day, Year) State Registrar

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Physiciar Medical Examin	1/	1. Decedent's Name (First, Midd	_{lle,Last)} anzlik	Spaul	ding		·		2. Date of D Month Novemb		Year	3. Time of Death 0723 hrs
		4a. Facility Name (if not instituti 14777 Roxbury Road	-	and number)		4b. City, Town, or Glenelg	Location of Do		4c. C	county of De	ath
Funeral Director	- 1	5. Social Security Number	6. Sex	∑ F 7. A⊊		ast birthday) 4 Yr	If Under 1 Yea Months Day		Min.	Birth (MM/DE	For	Birthplace (State or eign Pennsylvania Country)
215-0036 be filed within 72 hours after death with mal Hygiene. rked other than "natural", or items 23 cot, the Medical Examiner must be no	lo be completed by Funeral Directo	Usual Residence of Decedent 10a. State 10b. County Maryland Howal 10e. Street and Number 14// Roxbury 11. Marital Status 1 Never Married 2 N 15. Decedent's Education (Special Special S	Road 12. Was a larried a larried or Dates actify only higher Coll Coll Coll Coll Coll Coll Coll Col	ive Year ist grade cor lege (1-4 or 2 it)	G1 Ever in U No npleted) 5+) Attended Attended Met.	16a. Decede during n Admini 19b. Mailin 19 Oe Place of Dispo	as Decedent of His fes, specify Cuban Yes 2 No nt's Usual Occupa nost of working life LStration g Address (Street ella Aver sition (Name of ce her place) natory, Ir	metery, no, Mexican, Pu specify: tion (Give kind no NOT use 1 18.Mother's Na Margar et and Number nue Cata metery, nc . 1 s of Facility C	of work done retired) ame (First, Middle et Varga or Rural Route NONSVIlle Date 2/20/201	USA No- 14 Sp. 16b. Kin Fed. Fed. Lumber, City Anny 20c. Loc 2 Bal	White, etc pecify: White dof Busines eral (urname) or Town, Statland 2 cation - City timore	erican Indian, Black, nite ss/Industry Government ate, Zip Code) 2.1228 or Town, State
by the attending physician and the drough care the burial - transit	CYAIIIIIE	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last WUNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	e on each line. a. Etha Due to (c) Due to (c) d. AMEN a. Etha Due to (c) 1 1 1	or as a cons	equence of pregune of	enobar f): f): 8a-f, ponancy 2	er me,g9	toxicat	9-12 sm	23d. [Date of deliventh	Approximate Interval Between Onset and Death Pervenue of the control of the cont
	medical celtification. To be completed by	25. Was case referred to medica examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Peneral Natural 5 Coudete	Hospital: Hospital: Adding stigation 28ea. In the training on the training or training or the	Inpatie Date of Injudenting to deat Inpatie Date of Injudentin, Day, Y I 11-1 Place of Injudenting the best of massis of examiner stated.	int 2 int 2	ER/Outpatient 28b. Time of fd 7:15 ome, farm, stre d at he ge, death occu nd/or investigal	3 DOA njury 28c. Inju am 1 t, factory, office bome red at the time, da	e of Death (Che Other4 Nu ry at Work? Yes 2 No building, etc. ate and place, death occurre e number M.E.	1 Y 24a. Wa aut per 1 ✓ Yes 28d. Describ unknown 28f. Location or Town Glenei and due to the ca ed at the time, da	res 2 No as an opsy formed? s 2 No Residence how injury n (Street and, State) 14 i.g., MD. use(s) and rete and place 29d. Da Nover	24b. Were prior to death 1 e 6 Ott Occurred Number or 777 Romanner as st, and due to te signed (Amber 18,	Yes 2 No her: Scene Rural Route Number, City xbury Rd. ated. the cause(s) Month, Day, Year)
Stat Registra	~	31. Date filed (Month, Day, Year)		32. Registra				noro otteet	. Daminole, I	*ID 2 1220		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 08:00 AM Kawa l Samaroo 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital N/A Baltimore Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 TF Apr. 17, 1956Trinidad, WI Days Hours Director 56 Usual Residence of Decedent 10a. StateWI sho 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Trinidad St.Andrews Guaico Sangre Grande 1 Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a Mile Mark Guaico Tamana Road N/A Trinidad, West Indies 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Seamstress 8th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mungroo Sookhoo Ramdaie Beharry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 212348420 Kingsridge <u>Road Apt.A3 Parkville,MD.</u> Saui Khan/Daughter altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 Burial 2 🔀 Cremation 3 🗆 Removal from State 12/1/12 Caroni Trinidad, WI 4 ☐ Donation 5 ☐ Other (Specify) Caroni Cremation Site 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee uller 5240 Reisterstown Rd.Baltimore, MD. 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final COMPLICATIONS Onset and Death Physician/ OF VALVULAR MEART DISEASE Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Dire to jor as a consequence of it any leading to in medicause. Enter Underlying Cause (Disease or iinjury as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No Day Year Pregnant at time of death Other (specify) 1 Yes 2 L 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 1 NO 25. Was case referred to medical examiner? **Division of Vital** Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certific funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျှ 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending iniury 1. Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by determined Medical 29a. Certifie 1-KCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2
To the F only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MYSICIAN D0064533 11-20-LEVINDALE HEBREN

Registrar DHMH 17 Rev 7/2009

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State

BABATUNDE 31. Date filed (Month, Day, Year)

AMAROS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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GERLATRIC

2434 W. BELVESERE AVENUE GALTIMONE MS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death nt's Name (First, Middle, Last) Physician/ 16, 2012 10:32 AM vo vember Medical t institution, give street a Examiner Ellicott towa If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** yrs. last birthday) 1 🗆 M 2 🗹 Months **Director** 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Town or Location 10d. Inside City Limits Director timore 1 Yes 2 No 10e. Street and Number 10a. Citizen of What Country? 21215 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)/ 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ģ Yes 2 No 21215-0036 1 ☐ Yes 2 ☑ No Specify If Yes, Give Year or Dates 3 ₩Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NDT usere gred) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than College (1-4 or 5+) ager Be Maryland ners Name (First, Middle, Ma ဂ္ or other traumatic Important: If item 27 is any injury or other oute, Number, City or Court, atonsville Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or ether) Method of Disposition Nethod of Disposition

| Burial 2 | Cremation 3 | Removal from State 4 Donation 5 Other (Specify) organet afure of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DI TIS Physician/ lostnaum disease or condition resulting in death) Medical Examiner cause. Enter Underlying Cause (Disease or iinjury Examine scular DIACOR use as the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and that initiated events resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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To the Funeral Director:
completed filled in by the ☐ Suicide ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number ann D3064 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ramesh Sabapathi 201-109 Back RIVH Neck Road ESKX 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18, 2012 Scroggins November 3:07 Рм Ronald Μ. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Days **Director** 375-32-2554 1 X M 2 T F September 26, 1935 Michigan Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Montgomery Village Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20886 United States 19618 Enterprise Way 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 X No S, n S, でいた/ 人 , Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Financial Officer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen Webber Morgan Scroggins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 53 Byron's Place, Indiana, Pennsylvania 15701 Cindy Ann Lee / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Montgomery
Crematorium, Inc. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ovember 1. 2012 4 Donation 5 Other (Specify) Bethesda, Maryland . Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 John A. An M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tailure Multi-organ Priysician disease or condition Medical resulting in death) Due to (or as a confequence of) Examiner Sensis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of): sate has been signed by the attending physician page 2 should be detached for use as the burlal Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Lymphoma Advanced 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed Yes 2 this certificate within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) (2 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 11/19/2012 73826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 medical Ctr Dr Rockville, MD 20450 AmatyamD Birendra 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item I per doc 9933 II-20-I2 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Lucy Sheehan 3. Time of Death Physician/ Month Dav Year 4:05 AM 8 11 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Lorien Nursing Home Riverside Belcamp 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03/30/1940 Funeral 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign New York Director 1 □ M 2 1 F 125-32-9724 28e-f show permit. Page 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mental Hyglene. Importent: If Item 27 is merked other then "neturel", or Items 23e or 28e-f showny injury or other treumetic event, tre Medical Examples must be notified. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director X Yes 2 ☐ No Harford Belcamp 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21017 123 Belcamp Garth 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ₩ Widowed 4 Divorced Completed Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Loan Clerk Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Sullivan Lucy Pine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Sullivan / Brother 3701 Swift Run Ct., Abingdon, MD 21009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/20/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SUCe. Dorota Marshall Daule Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final -Pnysician/ ANDIUdisease or condition resulting in death)) Medical Due to (or as a consequence of): Examiner LOW Sequentially list conditions, if dry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). signed by the ettending physicien end d be deteched for use as the burlei-trensit or Attending Physicien: The lew requires that the deeth certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery Ectopic pregnancy 3 Pregnant at time of death Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś cate hes been sig ; pege 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 1 within 24 hours efter death.

To the Funerel Director: After this certificate completely filled in by the funerel director, peg 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospitel Medical 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who comple ted cause of death (Item 23a) (Type, Print) MAC 31. Date filed (Month, Day, Year)
NOV 2 0 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER Pay 1 4 2012 ROLANDO SCHIAVONI 07:30PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number **Funeral** 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 205 22 2471 Days Hours Director 1 M 2 🗆 F 05-12-193 PA Usual Residence of Decedent or than "natural", or items 23e or 28a-f show the Modical Examinar must be notified at filed within 72 hours efter death with the Maryland 10a, State Director 10c. City, Town or Location 10d. Inside City Limits WD Frederick Walkersville 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 21793 105 Sandstone DY, APY 319 us 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 2 Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 N Widowed 4 □ Divorced If Yes, Give Completed Specify: Winte Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) HEWSDADEY Transportation Manag permit. Page 1 and 2 should be filed Depertment of Health and Mental Hyg Importent: If item 27 is marked other eny Injury or other traumatic. Be other traumatic event, 17. Father's Name (First, Middle, Last) မ Schlaroni Dominic Gertrude Piglini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) White daughter Melanie Green wich Dy walkersville MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place. NOV, 17, 2012 Cunningham Memorial Co ST. ALBAUS WIZT VIRGILIA 21. Signature of Funeral Service Licens 22. Name and Address of Facility 110 W South ST POBOX 350 L. Rollins Funeral Home Frederich MD 21705 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physicien: The law requires that the death certificate be execute burs after death. eral Director: After this certificate hes been signed by the ettending physicien and filled in by the funeral director, pege 2 should be detached for use es the burlal-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 🗆 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in the cause of examination and/or investigation. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 36 68 30. Name and address of person who completed cause of death (Item 23a) (Type,

State

Registrar

31. Date filed (Month, Day, Year)

NOV 20

2012

32

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5perff, 6933, 11/26/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:30a M William Shird 11 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Genesis Homewood Center Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 07/13/ 7. Age (In yrs. last birthday) -3384-17374-1860 **Funeral** Year) Days Hours 1**∑** M 2 ☐ F 8360 MD 73 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Mudical Exprise incrinst by notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1√2 Yes 2 □ No MD N/A Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 118 Upmanor Rd. 21229 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 ☐ Married 1 ∐Yes 2 😿 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) UNK Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grady Shird Wilhemina Washington ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9717 Cypress Wood Dr. #423 Houston, TX 77070 Tauscha Shird (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State On-Site Crematory 11/20/12 Baltimore, MD Other (Specify) 4 Denation 21. Signature of Funeral Service Lice Name and Address of Facility Joseph H. Brown, Jr. Funeral Home PA 2140 N. Fulton Ave. Balto., MD 21217 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each in e. Approximate Interval Between Onset and Death 23a. Pa. 1. Ever the diverse se nock, r heart filt re. L Immediat, Cause (Final **Physician** discusse or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Exam physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 2 No 3 Probably 4 Hiknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ Ho 24a. Was an has autopsy 2 🔼 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 ⊟Natural Injury 5 Pending thours after death...uneral Director: Af 1 ☐ Yes 2 🗌 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 204, Parkilly, MD-21234 ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add woods

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician/ Month Mary D. Snell 2012 1845 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Days Hours Director 240-46-2339 1 □ M 2 🔀 F 84 Dec. 3,1927 South Carolina 2 should be filed within 72 hours after death with the Mayland th and Mental Hygiana. 27 is marked other than "neturel", or items 23e or 28e-f show treumatic event, the Medical Evaminar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery MD Chevy Chase 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8100 Connecticut Avenue 20815 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White 3℃Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secondary Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Belle Jenrette James Dickson DeVane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Paga 1 end 2 si tmant of Heaith a tent: If item 27 is jury or other tre 3907 Jocelyn St. NW Washington, DC 20015 Mary Cohen / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State parmit. Paga 1 e
Dapartmant of IImportent: If ite
eny injury or ot cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State <u> Final Journey</u> Crematory 11/21/12 4 Donation 5 Other (Specify) Woodbine, MD 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Liger M01251 Beverly L. Heckrotte, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between seconds Immediate Cause (Final Pnysician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Aortic Dissection - Perforation days Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a nonsequence of pata has baan signed by the attending physician end pega 2 should be detached for usa as the burial-transit Atherosclerosis years Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death 9 Unknown To the Hospital or Attending Physician: The law raquiras that the within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the completaly filled in by the funeral director, pega 2 should be detach. P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ▼No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Snell, Mary performe 1 ☐ Yes 2 🔀 No Yes 2X No 25. Was case referred to medical a 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2X No |요 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 XNatural 5 Pending 2 Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medicat 29a. Certifier 1 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Deficial Examiner: On the gasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person

31. Date filed (Month, Day, Year)

why completed cause of death (Item 23a) (Type, Print) Jack Flyer 8600 Old Georgetown Road Bethesda, MD 20814

MA060887

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G935 1/15/2013 JH State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 330 PM Medical Sounty of Death Examiner 4a Facility Name (if not institution 4b. City, Town, or Location of Death IMONIL If Under 9. Birthplace (State or Foreign **Funeral** Date of Birth Months (Month, Day, Year) Hours Min. Country) 579-26-8120 **Director** 1 M 2 87 26, 1925 Illinois May Usual Residence of Decede iral", or items 23a or 28a-f show Examiner must be notified at the Maryland 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12261 Roundwood Road 21093 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", If Yes, Give Specify 3 X Widowed 4 Divorced Completed Year or Dates White event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) 12 03 Legal Secretary General Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles Pelton Rose Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Barbara Jean Speckart/Daughter 1742 Uniontown Road, Westminster, MD 21158 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1/11/2013 ö 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Arlington National Cemetery Arlington, Virginia 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 Clary Bryan W 23a. Part 1. Enter the disease, or complications the shock, or heart allure. List only one cause. I Immediate Cause (Final disease or condition as the shock of t the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ending physician and use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant yes, outcome of pregnancy 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death for in the past 12 r 1 Yes 2 No 9 Unknown Month Year Pregnant at time of death detached þ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 perforn death? 2 No 1 Yes 2 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify this 27. Manner of Del 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural
2 Accident 5 Pending injury 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one d title of certifie 29b. Signater 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day William Howard Stotz Nov. 2012 8:39 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Center Baltimore Towson . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) Director 206-20-2161 1 🛛 M 2 🗆 F 86 Oct. 13 1926 PA l Hyglene. other than "natural", or items 23a or 28e-1 shot vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Pege 1 and 2 should be filed within 72 hours efter deeth with the Maryland Director 1 Yes 2 No Baltimore Lutherville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 Pickett Garth Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: white Completed 3 √ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Radio Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Engineer Communications Ith end Mental Hygle 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ John Kenning Stotz, Sr. Josephine Stevenson Martha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i James W. Stotz/son 2 Pickett Garth, Lutherville, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Importent: If its eny injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11/19/12 Glen Burnie, MD 21. Signature un puls river Licensee 22. Name and Address of Facility emmon Funeral Home of Dulaney Valley, Inc. 0 W. Padonia Rd., Timonium. MD 21093 Flagle 23a. Part 1. Enter the disease. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ uu disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) 24 hours after death.
24 hours after death.
2 Funeral Director. After this certificate has been signed by the ettending physician end or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death W. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed' 1 Yes 2 No 1 ☐ Yes 2 ☐ N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Parties was ball 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 112 Investigation 112 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Pick of Goute 4 Homicide determined 2 PICKETT Goute AT HOME To the Hospital or within 24 hours aft To the Funeral Dir completely filled in Medical 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

(Check only one) 29b. Signature and title of certific

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 2 0

Get trying regards to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2012 Lois Ann Stewart 10:55 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 602 A Powder Mill Drive Fallston Harford 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days Min. (Month, Day, Year) Hours 219-32-6719 Director 1 M 2 T F 76 May 16, 1936 Maryland 1 end 2 should be filed within 72 hours efter deeth with the Merylend of Heelth and Mental Hyglene.
Item 27 is marked other then "neture!", or items 23s or 28e-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 602 A Powder Mill Drive 21047 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 ₩ Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse's Aide Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Newton Rigney Beulah Parlett Shannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 end 2 3508 Royal Scotts Way, Fort Smith, AR 72908 Linda Rush / Daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of F importent: if Ite sny injury or oth 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Rose Hill Svcs. LLC 11-20-2012 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. ence Luxave 50 W. Broadway, Bel Air, Maryland 21014 And 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) severe Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ths attending physicien end hed for use as the burial-transit To the Hospital or Attending Physician: The lew requires thet the deeth certificete be executed within 24 hours efter deeth.

To the Funerei Dirsctor: After this certificate has been signed by the attending physicien and completely filled in by the funerel director, page 2 should be deteched for use se the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Day Pregnant at time of death 2 - No 1 Yes 2 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ል 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Ves 2 N 25. Was case referred to medical examiner?

1 Yes 2 Ho Division of Vital Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License number D16444 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATWOOD Road 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOV. 17^{pay} 2012^{ear} 11:55 A M MARY ELIZABETH SADLER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7005 DUNMAN WAY APT A DUNDALK BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Hours 216-38-4449 71 Director 1 □ M 2 X F 7/17/1941 MD show the Maryland 10a State 10b. Count aţ 10c. City, Town or Location 10d. Inside City Limits Director notified BALTIMORE MD DUNDALK 28a-f 1 Yes 2 X No 10e. Street and Number ms 23a or must be r 10f. Zip Code 10a. Citizen of What Country? Funeral 7005 DUNMAN WAY APT 21222 USA er than "natural", or items the Medical Examiner mus 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after 1 Yes 2 No Specify Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2 SCHOOL TEACHER **EDUCATION** Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည MILDRED ADAMS CHARLES GUTRIDGE 19a. Informant's Name/Relationship (Type, Print)
CLIFFORD SADLER-HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7005 DUNMAN WAY APT A BALTIMORE, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State . Page 1 a 1 X Burial 2 Cremation 3 Removal from State ATLANTIC CREMATORY 11/20/12 GLEN BURNIE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER AND SON oun 6224 EASTERN AVE BALTIMORE, MD 21224 234. Part 1. Ease the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lmonn disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine for use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Yes 2 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

N. Charles St. Balto. M. 2 (20)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 9:05A PETER SECHAK NOVEMBER 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS TIMONIUM BALTIMORE If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 AM 2 □ F Director 18-48-4714 MARYLAND 62 5-10-1950 Usual Residence of Deceder 2 should be filed within 72 hours after deeth with the Maryland th and Mentel Hygiana. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Maclical Eventher mast be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director HARFORD FOREST HILL 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1905 MUNSEY DRIVE 21050 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. 1 Never Married 2 Married ፩ 1 ☐ Yes 2 🙀 No Specify: WHITE 3 Widowed 4 Divorced Completed fear or Dates. 1971-1976 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) DISTRICT MANAGER FOOD SERVICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ PAUL SECHAK, SR. permit. Paga 1 end 2 should be Depertment of Heeith and Men Important: if Item 27 is marku any injury or other traumatic <u>once.</u> BERNICE KULACKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANNE SECHAK **SPOUSE** 1905 MUNSEY DRIVE FOREST HILL, MD. 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HIGHVIEW MEMORIAL 11-20-2012 FALLSTON, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BEL AIR 610 W. MACPHAIL ROAD BEL AIR, MD.21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ma Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Aftar this cartificata has bean signed by tha attanding physician and a funarai diractor, pega 2 shouid ba datachad for usa as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ECHRIC DETER Box 68760 Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Using Birth 2 Fetal death
Pregnant at time of IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 2 No 1 🗆 Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 X No ဍ 1 Inpatient 2 ER/Outpatient 3 IDOA Other (Specify) 27. Manner of Death Natural 2 Accident Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending daeth. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours aftar daeth To the Funeral Director: A complatally fillad in by tha f tha Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, dyam occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and infinitesity of interest and place, and due to the cause(s) and manner as stated.

Continuing Jurise Practitioner: To the basis of examination and infinitesity of the cause(s) and manner stated. (Check only one 29b. Signature and title of pertit 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of d State Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vo Vember 270 PM Mark Stancil 2012 Lynwood Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** 246-48-6735 Director **X**X M 2 □ F 80 6/12/1932 N.C. 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "netural", or items 23a or 28a-f sho amy injury or other traumatic event, the Modical Examiner order be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2XXNo Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 786 Jennie Drive 21144 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married * Married ▼ Yes 2 No If Yes, Give 1 Yes 2XXNo Specify: Completed White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Maryland Director 6 Rehabilitation Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ۵ James Stancil Ida Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Joan M. Stancil / Wife 786 Jennie Drive Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 11/23/2012 Glen Burnie, MD Atlantic Crematory Signatury 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** te Renal failure Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of): g physicien and as the burlat-transit the Hospital or Attending Physician: The law requires that the deeth certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 tor. After this certificate has been signed by the attending p the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months? Month Other (specify) Day Year Yes 2 No 1 Yes 2 9 Unknown 9 Ulnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 2 No 1 Nonpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 24 hours efter death. Funeral Director: Af Accident 1 Yes 2 No Investigation To the Hospital or Atter within 24 hours efter dea To the Funeral Director completely filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Law Compsel CRIP R118453

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State Registrar 31. Date filed (Month, Day, Year) NOV 2 0 2012

Glen Burnie, MD

301 HOSPITAL Dr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHANEN CAMPBELL CRUP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ November 18. Helmut Sonnenheldt 12:30рм 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Brighton Gardens Chevy Chase Montgomeru 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) Hours 220-24-1480 Director 1 X M 2 □ F 86 09/13/1926 Germany ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Chevy Chase 1 Tes 2 No Montgomery 10f, Zip Code 10g. Citizen of What Country? Funeral 5600 Wiscinsin Avenue, #1504-05 20815 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 V Yes 2 No Army
If Yes, Give Black, White, etc. 1 Never Married 2 X Married <u>۾</u> Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed WWII Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. ie marked other than life. DO NOT use retired College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Career Minister U.S. Dept. of State it. Page 1 and 2 should be filed w rdment of Hoalth and Mental Hygi rdant: If item 27 ie marked other njury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dr. Walther Sonnenfeldt Dr. Gertrud Liebenthal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5600 Wisconsin Ave., #1504-05, Chevy Chase, MD 20815 Marjorie Sonnenfeldt - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1
Depertment of I
Important: If its
any injury or of 1 Burial 2 Decremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory: 11/26/2012 Baltimore. Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinalai runeral Home, Inc. 1800 New Hampshire Ave., Silver Spring, MD 20904 Mand 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
O Years Immediate Cause (Final Physician/ Alzheimer's disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Examine Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, pege 2 should be detached for use as the burlal-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Other (specify) Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place. Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the course(s) and munner as state only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD12568 November 19, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.3301 New Mexico Avenue. NW #350. Washington. DC Thomas Sacks,

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

NOV 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NO NEMBER 13, 2013 Physician/ 5: 19 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Cester Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 71 594-53-1599 1 ÅM 2 □ F Director Korea 10/01/1941 ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City. Town or Location Director 1 ☐ Yes 2 🕅 No Silver Spring Montgomery Maryland 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 20901 U.S.A. 321 University Blvd., West, #202 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Asian 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Should be filed within 72 thand Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Government Transportation Bus Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hyae Yuhn Lee Jae Byul Song 1 and 2 should b of Health and Mei item 27 Is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 University Blvd., W. #202, Silver Spring, MD 20901 Hong Im Song - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1.
Department of 1.
Important: If its
any injury or of Page 1 1 🗌 Burial 2 🕅 Cremation 3 🗌 Removal from State Lincoln Crematory 11/27/2012 Brentwood, Maryland 4 ☐ Denation 5 ☐ Other (Specify) 21. Signature of Funeral Service is nisee 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STEMi 2 HOURS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner <u>UNKWON</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by AiM3)QA 3T 23JOHD A39PH 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 \$\mathbb{M}\$ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 ■ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Su and aryundlind D0065 +1A HONEWBER 17, 5015 e of death (Item 23a) (Type, Print) 301 HOSPITAL DRIVE, GLEW BURNIE, MO 20161

DHMH 17 Rev 06-2011

State

Registrar

SUICLERMO DOSE

NOV 20

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37362 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 95, 2012 William Frederick Smith 11:55 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring 3501 S. Leisure World Blvd. #1C If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours February 1925 Caffädda Director 721-10-5536 87 1 X M 2 □ F 12 should be filed within 72 hours after death with the Maryland ath and Mertal Hygiene.
The marked other than "natural", or items 23e or 28e-f show transitio event, the Maddeal Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 Canada 3501 S. Leisure World Blvd. #1C 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married <u>۾</u> Maryland 21215-0036 Specify: White 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Captain Fire Department æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Eleanor Naves Frederick William Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 3501 S. Leisure World Blvd. #1C Silver Spring, MD 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 end 2 sh Department of Heath ar Important: If item 27 is any Injury or other trau Verna May Smith/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State Final Journey Crematory 11/17/2012 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Sing Home Cremation Service MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, scaling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of, Coronary Artery Disease e Hospital or Attending Physiclen: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

Puneral Director. After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Renal Failure 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

To the Hospital or Atte within 24 hours after de To the Funerel Directo completely filled in by the

Registrar DHMH 17 Rev 06-2011

State

only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

NOV 2 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year) 11-16-1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	Marylanc				nd Mental Hy	giene	0010	03000
			State Registrar		Cen	tificate of D	Death	- 1	Reg. No.	<u> </u>	3/303
	Physicia	n/	Decedent's Name (First, Middle, Last)					Date of De Month	Day	2012	3. Time of Death 2030 M
The state of the s	Medic Examin		Terry Craig Sheerer 4a. Facility Name (If not institution, give street and number	er)		4b. City, Town, or	Location of I	Death		County of Deat	
**	£ Adiiiii	e.	Atlantic General Hospita	1		Berlin				Worches	
	Funeral			Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bird			hplace (State or Foreign untry)
	Director		221-38-0193 1 X M 2 □ F	62	Yrs.	Month Days	110070	08/01			nnsylvania
	show dat	ក្ន	Usual Residence of Decedent 10a. State 10b. County		Town or Loc	ation		00/02	, 200	0 1101	10d. Inside City Limits
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	the N n or 2		10e. Street and Number		4	10f. Zip Code			10g. Citi	izen of What Co	untry?
	n with	Funeral Director	38798 Tyler Avenue			1997				S.A.	
	deatl r iten		11. Marital Status 12. Was Decede Armed Force	es?	13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin n, Mexican, F	1? (Specify Yes or No- Puerto Rican, etc.)		 Race - Ame Black, White 	
336	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 1 😿 Yes 2 If Yes, Give Year or Date	□ No	1	☐ Yes 2 🛣 No	Specify:			Specify: Whi	ite
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ary .	should and Me is mar raumati		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	g Address (Street a		or Rural Route Numbe		Town, State, Zip	Code)
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$\mathcal{M}\mathcal{ZOSO}$. Baltimore, Maryland 21215-0036	of Heal		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from St		ace of Dispos metery, crem	sition (Name of atory or other plac	e)	Date	20c. Lo	ecation - City or	Town, State
ti X	permit. Page 1 Department of Important: If i any injury or o		4 🛛 Donation 5 🗆 Other (Specify)	Ana				./19/2012		over, Ma	
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12	Ph_sician/		shock, or heart failure. List only one cause on each Immediate Cause (Final	line.	Δ	Guse				9	Interval Between Onset and Death
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55	ificate k ng phys as the	Med	IF FEMALE:								
9×	tendir ruse	ian/l	23b. Was decedent pregnant 23c. If yes, outco	th 2 🗌 Fetal	death 3 🗌	Ectopic pregnanc	y			23d. Date of de Month	livery Day Year
Division of Vital Records, P.O. Box 687	sician. The law requires that the death certifica certificate has been signed by the attending priector, page 2 should be detached for use as it	Completed by Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregna 9 ☐ Unknown 9 ☐ Unknown	nt at time of de wn	eath 5 □	Other (specify)				World	Day
800	hat th ed by detac	y Ph	Part II. Other significant conditions contributing to dea	th but not resul	Iting in the ur	nderlying cause giv	ven in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
S. Is.	uires t n sign uld be	q p						1□	Yes 2	□ No 3 □ P	robably 4 🗆 Unknown
9 50	w req is bee 2 sho	plet						24a. Was		24b. Were au	topsy findings available completion of cause of
Rec	The la ate ha page	E						perfo	ormed?	death?	3 2 No
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of Vit	Physi this c	<u>ان</u>	1 Yes 2 No 1 In In 27. Manner of Death 28a. Date of	patient 2 1	R/Outpatient	t 3 DOA Othe	4 □ Nurs	sing Home 5 Resi			ify)
Loui	tending Phileath.	cate	1 ■ Natural 5 □ Pending (Month, 2 □ Accident Investigation	Day, Year)	injury	work	Yes 2□N	1	now injury	Coccurred	
isio	I or Attendi after death. Director: A d in by the fu	Certificate:	3 Suicide 6 Could not be 28e. Place of	Injury - At hom , etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (ral Route Number,
Div Div	ital or irs afte al Dir lled in		(4.0)					0			
Sheerel Divi	To the Hospital or Atter within 24 hours after dea To the Funeral Directo completely filled in by th	Medical	29a. Certifier 1 Certifying Physician: To the bess 2 Medical Examiner: On the basis	t of my knowle of examination	dge, death o and/or investi	ccurred at the time	e, date and pl on, death occu	lace, and due to the curred at the time, date	ause(s) ar and place,	nd manner as st	cause(s) and manner stated.
S	To the within 7 To the comple	Σ	only one) 3 Certifying Nurse Practitioner: T 29b. Signature and title of certifier	o the best of my	r Knowledge,	29c. License	number	and prace, and due to	29d. Dat	(s) and manner a te signed (Monti	
	- 2 - 0		PME) PME			H-201	197		11/1	412	
	•		30. Name and address register who completed cause	of death (Item 2	Carro	rint)	Salish	and place, and due to	1801		
	Sta Registr		31. Date filed (Month, Day, Year) 32 Reg	istrar's Signatu	re An	Des de la la la la la la la la la la la la la					
			NOV 9 () 2012 Com	eas po	1			_			

10V

Registrar

Joceline Kouatchou

DHMH 17 Rev 06-2011

Onset and Death

3. Time of Death

10201 2012

4c. County of Death Montgomery

9. Birthplace (State or Foreign

Washington, DC

10d. Inside City Limits

1 Yes 2 X No

U.S.A.

14. Race - American Indian Black, White, etc. Specify: White

16b. Kind of Business/Industry

Funeral Home

3481 S. Leisure World Blvd., Silver Spring, MD 20906

20c. Location - City or Town, State Silver Spring, MD

22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc.

11800 New Hampshire Ave., Silver Spring, MD 20904 Approximate Interval Between

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕊 Unknown

Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes

4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

1 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 29c. License number Joselyne Kouertchou, ms D63748

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Montgomery Medical Center Medoren

Hevember, 15,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NoV. Alberto C. 2012 Seiguer 12:50 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Stella Maris Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Funeral 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign (Month, Day, Year) Director 265**-**21**-**6563 1 X M 2 □ F 75 June 16 1937 Argentina and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10h Count 10c. City, Town or Location 10d Inside City Limits Director 1 🗌 Yes 2 🗓 No Marvland Baltimore Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17112 Old York Road 21111 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Medical Doctor Pathology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jose Seiguer Raquel Schenkelman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amalia Seiguer / Wife 17112 Old York Road, Monkton, Maryland or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Importent: If ite
any injury or ott 1 Burial 2 X Cremation 3 Removal from State HilltopServiceCorp. 4 ☐ Donation 5 ☐ Other (Specify) 11/20/2012 Towson, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Ruck Towson Funeral Home 1050 york Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, END STAGE CARDIAC DISEASE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examiner Due to (or as a consequence of) erel **Director:** After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicial of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Yes 2 □ No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X N 2 🗆 No 1 Tes Se Se 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) HOSPICE ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and ti signed (Month, Day, Year, of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar **JONES**

CRNP

2012

NOVEMBER 17,

ALBERTO SEIGUER

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** tevens 1.26PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ler i Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day Year | 19 40 Baltimore Cit nna Birthplace (State or Foleign Country) 5. Social Security Number **Funeral** 1 M 2 V 502-42-9840 Director North Dakota Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 📆 Xlo Maryland | Anne Arundel Severn Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1576 Red Haven Drive 21144 **USA** Completed by Funeral Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. I □ Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify SpecWhite 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Assistant Heart of America 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raleigh Austin Jane Greene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Diane K. Lowe/daughter 7867 W. Riverside Drive Pasadena MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/2013 Persilla Watts Cem 4 ☐ Donation 5 ☐ Other (Specify) Rugby North Dakota 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. 5305 Harford Road Baltimore MD. 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) atherosclerosis **Physician** oronari /Medical Due to (or as a consequence) Examiner Sequentially list conditions, if any, leading to intribute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as for use a IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 □ No 3 ☐ Probably 4 MUnknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an has autopsy perform certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manper of Death 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier uppling. CRNP 120938 12

DHMH 17 Rev 1/2001

State Registrar

Naltham Woods Road Parkville, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anna M. Thompson Month 2012 2:30 a M November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brinton Woods Nursing Center Sykesville Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Director 215-34-0808 75 Yrs March 17 1937 Usual Residence of Deced er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Woodbine 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15401 Frederick Road 21797 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed 3 X Widowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) food service cafeteria aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked o traumatic eve မ Anna M. Powell Bernard K. Feaga t. Page 1 and 2 should be thent of Health and Menrant: If item 27 is marken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Roosevelt Rd., Sykesville, MD 21784 Mr. H. Lee Thompson (son) Department of Healt Important: If item 2 any injury or other tonce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 A Burial 2 Cremation 3 Removal from State 11-21-12 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Paige of aight oferbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a cons y uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): physician and that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Dav Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 🖺 No မ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Waturat 5 Pending 1 Yes ☐ Accident Investigation 2 🗆 No ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date/signed (Month, Day, Year) 020806 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21/36 31. Date filed (Month, Day, Year) State NOV 2 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Thomas Travers 2ď12 November 9:26 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Genesis Cromwell Center Parkville Baltimore 9. Birthplace (State or Foreign Country) Scotland Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Dec. 24, 1921 **Funeral** 7. Age (In vrs. last birthday Days 1 X M 2 □ F Director 90 179-12-2060 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Marvland Baltimore Parkville 1 ☐ Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7912 Ridgely 0ak Road 21234 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: White WWII Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Artist Packaging Design 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Travers Elizabeth Grieve 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Travers / Wife 7912 Ridgely Oak Road, Parkville, Maryland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 11/17/2012 | Baltimore, Maryland (T 21. Signature Pineral Service Licensee Alyson R Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter ng, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one car Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) signed by the cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Other: ျပ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA n 24 hours after death.

ne Funeral Director: After the oldered filled in by the funeral the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending Investigation 6 Could not be 1 Yes 2 🗌 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nov. Day 7:35 P M 2017 Sadie Tate Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NA Future Care Sandtown Winchester Baltimore 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Min. Hours 245-28-6353 86 Director 10-02-26 Usual Residence of Decedent show with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Yes 2 No 28a-f NA Baltimore 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 4829 Williston Street 21229 USA Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. African p 1 Yes 2 XNo
If Yes, Give
Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: American Completed 3X Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 10th Grade Home maker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk. ပ Isabelle Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tate-Daughter 4829 Williston Street Baltimore, Maryland 21229 Angela Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State □ Burial 2 Cremation 3 Removal from State
 □ Donation 5 Other (Specify) Metro Crematory or other pla 11-23-12 Catonsville, MD 22. Name and Address of Facility Signature of Funeral Service Licensee Wylie Funeral Home P.A. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Ooset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a conse the burial-transit been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be thin 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Year Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Director: After this certificate has autopsy death? performe 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury aj 28d. Describe how injury occurred injury Natural 5 Pending work' 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signat 29c. License numbe 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) Name and addre

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed

Dav. Year

NOV 2 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day AM **Physician** 1:10 Nicole Taylor - Brooks 17 November 2012 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 214-88-952 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural" -- " any injury or other traumatic events. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No Director imove 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral amona 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban Mexican, Puerto Rican, etc.) 11. Marital Status 2 No 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 21 No 1 Tyes Specify þ 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ay/01 Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or 14imore MO212/3 Subbeti 401 Kamona 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Salfimore, MD 4 ☐ Donation 5 ☐ Other (Specify) D22. Name and Address of Facility Vaughn (4905 York Road, 1 21. Signature of Funeral Service Licensee 1101553 139/X Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) 40005 Due to (as a consequence of) hypertenarum Danit der sie a consequence of 4cm 5 Sequentially list conditions, if any, eaching to him condic cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery

Physician /Medical **Examiner**

þ

Completed

Be ၉

use as the burial-tran

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 🏂 Unknown	1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3	_
Part II. Other significant condition	ns contributing to death but not resulting in	the underlying cause given in Part I.	

	1 ☐ Yes 2 [No 3 ☐ Probably 4 ☑ Unknown							
	24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑No							
C	heck only one)								
е	5 Residence 6	□ Other (Specify)							
80	d. Describe how injury occurred								

4940 Eastern Avenue, Baltimore, MD, 21224

Month

23e. Did tobacco use contribute to the cause of death?

Day

Year

		1 ☐ Yes 2 No 1 ☐ Yes 2 No								
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 Mayes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom	me 5 Residence 6 Other (Specify)								
27. Manner of Death 1	(Month, Day Year) Injury Work?	28d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier 1 Certifying F	Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the cause(s) and manner as stated.								

	1/2	- MD		00069477	November 17 2012			
Me	29b. Signature and title of cenifier		2	29c. License number	29d. Date signed (Month, Day, Year)			
dical				ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)				
Certific	3 Suicide 6 Could not be determined	28e. Place of injury - At he building, etc. (Specif		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
tification:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred			

LIEM WALL	A Child I
. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 2 0 2012	Depuns S. fork

DHMH 17 Rev 1/2001

completely

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			ForState	State of Marylan		artment of I			2111	37371
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	TICKER				2 Date of Dea	tth Day 20	3. Time of Deeth
Andrews.	Medic Examin		4a. Facility Name (if not institution, give st	reet and number)			r Location of Dea	th	4c. County of De	
	Funeral Director		213 20 2331	M 2 □ F	ast birthday) Yrs.		If Under 24 Hr Hours Mir		h 9. E	Sirthplace (State or Foreign Country) Maryland
	aryland ta-f show ified at	Director	Usual Residence of Decedent 10a. State 10b. County MD	10c. Cit	y, Town or Lo					10d. Inside City Limits 1 🛣 Yes 2 □ No
	with the M 23a or 28 ust be noti	Funeral Dir	10e. Street and Number 2500 W. Belvedere	•		10f. Zip Code 21215			10g. Citizen of What	Country?
980	permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			2. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	3. 13.	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🛛 No	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	Black, Wh	nerican Indian, nite, etc.
21215-0036	within 72 hou giene. er than "natu the Medical	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give life. D	dent's Usual Occup kind of work done O NOT use retired, Ver Worke	during most of w	orking	16b. Kind of Busines	worked
Maryland	should be filed or and Mental Hyg is marked other raumatic event,	To Be	17. Father's Name <i>(First, Middle, Last)</i> James Tucker				18. Mother's N Luven	ame (First, Middle, ia C	Maiden Sumame) Curley	
	end 2 shoul Health and I tem 27 is ma		19a. Informant's Name/Relationship (Typ Kimberly Carroll	/ Niece	506 1	North Pac		t, #11, E	r, City or Town, State, Baltimore,	MD 21201
Baltimore,	permit. Page 1 e Department of H Important: If Ite any injury or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 💆 Donation 5 ☐ Other (Specify)	Removal from State	emetery, crer natomy (try 11/		20c. Location - City Hanover, I	Maryland
Bal	permit Depar Impor any in		21. Signature of Funeral Service Linnser 23a. Part 1. Enter the disease, or compli	-	7.	522 Conne	elley Dr	., Ste. I	fts Regist , Hanover	, MD 21076
	nysician/ Medical		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line. Cardio Due to (or as a consequence) Atheroscle						Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence).		Cardie	rascul	ar Disan	28	
0	Hospital or Attending Physician: The law requires that the death certificate be executed thours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use es the burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	uence of):			<u> </u>		
876(tificate ng phys es the	Medi	IF FEMALE:							
. Box 6876	ne death certificate b y the attending physiched for use es the k	Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Fet: 4 ☐ Pregnant at time of a 9 ☐ Unknown	aldeath 3	☐ Ectopic pregnan☐ Other (specify) _	су		23d. Date of Month	delivery Day Year
ds, P.O.	requires that the dea been signed by the a should be detached i	ted by PI	Part II. Other significant conditions cor	tributing to death but not res	sulting in the u	underlying cause g	iven in Part I.			to the cause of death? Probably 4 Onknown
Division of Vital Records,	sician: The law re certificate has be lirector, page 2 sh	Comple				_		24a. Was autop perfo 1 🗌 Yes	osy prior to death	autopsy findings available o completion of cause of ? res 2 No
/ital	ysician s certifi director	To Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐	EB/Outpotio	Ott	lace of Death (Cl	neck only one) Home 5 Resid	dence 6 Voltage	ment hospice
on of \	anding Phy ath. rr. After this he funeral	Certificate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time o injury	f 28c. Inju wor	ry at	_	ow injury occurred	ecity)
Divisi	ital or Attendi urs after death ral Director: A lled in by the f		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		reet, factory, office		28f. Location (S City or Tow	Street and Number or rn, State)	Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	Medical	(Check 2 Medical Examination	cian: To the best of my know er: On the basis of examination Practitioner: To the best of	n and/or inves	tigation, in my opin , death occurred at	ion, death occurre the time, date and	d at the time, date a	and place, and due to the he cause(s) and manne	e cause(s) and manner stated. er as stated.
	७ ≱ ७ ৪		> nsRy	iapahem			5746	5	29d. Date signed (Mo	MO ZIZOG
	Sto	10	30. Name and address of person who con NS Ry ap a K-FC 31. Date filed (Month, Day, Year)	MD 2835	Smi	the AV	3203	Ba	Homore	MO 21209
	Sta Registr		NOV 2 0 2012	32/Registrar's Signa	1. spa	we				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Varghese Thomas 2:10 pm November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6913 Good Luck Road New Carrollton Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 219-82-6910 1 **X** M 2 □ F Director 75 March 15,1937 India r than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Prince George's New Carrollton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6913 Good Luck Road 20784 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced If Yes, Give Asian Indian Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 72 lath and Mental Hygiene.
27 Is marked other than "r r traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Varghese Thomas Mariamma (Unknown) t. Page 1 and 2 should be tment of Health and Mer rtant: If item 27 Is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saramma Thomas - Spouse 6913 Good Luck Road, New Carrollton, Maryland 20184 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 11/16/2012 | Silver Spring, MD . Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring. MD 20904 use of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cust only one cause of each line. 23a. Part 1. Enter the disease, Approximate Interval Between Onset and Death shock, or heart failure Immediate Cause (Final Physician/ disease or condition resulting in death) Septicemia Medical Due to (or as a consequence of): Examiner <u>Cholangiocarcinom</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month ate has been signed by the a page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown 24b. Were autopsy findings available prior to completion of cause of death? History of Percutaneous Transluminal Coronary 24a. Was an After this certificate has Angioplasty 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🕅 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practifioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number eted cause of death (Item 23a) (Type, Print) 10V

Registrar
DHMH 17 Rev 06-2011

M.D.,

6525 Belcrest Road,

Hyattsville, Maryland 20782

Ellen Finkelman,

31. Date filed (Month-Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltmore >hirlen If Under 24 Hrs. Hours Min. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) 0477 84 4970 367-66-3774 42 MI Director 1 □XM 2 □ F Yrs ral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location Baltimore Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. Hast if item 27 is marked other then "natural", or items 23a or 28a f sho ury or other traumatic event, if a Medical Examiner must is notified at ury or other traumatic event, if a Medical Examiner must is notified at 10a. State 10b. Count 10d. Inside City Limits Director MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 USA 2472 Shirley Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. 2 1 Never Mamied 2 Married Baltimore, Maryland 21215-0036 Black 1 Yes 2 XNo Specify: It Yes, Give Year or Dates. 1989-96 If Yes. Give 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 or 5+) 4yrs Elementary/Secondary (0-12) Welder Construction æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) စ Charles Tiller Willie Lee Warren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Samuel Buckley Brother 667 Camden Court Rochester Hills MI 48307 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 D Removal from State Atlantic Crem permit. Page Department of Important: If any injury or once. 11/18/12 Glen Burnie MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Simplicity Crem & Fun Serv Ton ThomasAllenPA 7090 Ridge RD Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician Medical resulting in death) Due to (or as a conseq Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ል 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examinating and/or investigating in the cause of examinating and or investigating and or investig 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and

North Greene Street Buttimore

pleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 55 AM Ovembe Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Madical Center Inne Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth **Funeral** Hours 212-30-5987 0270271933 Director MD 1**X** M 2 □ F "natural", or items 23a or 28a-f show dical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified to once. 10b. County 10c. City, Town or Location 10d, Inside City Limits Director MD Anne Arundel Severn 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21144 Funeral 1776 Sea Pine Circle USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Bace - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 XYes 2 If Yes, Give Baltimore, Maryland 21215-0036 Black If Yes, Give 1954-76 Year or Dates. 1 ☐ Yes 2 X No Specify: 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 2yrs Elementary/Secondary (0-12) Air Force Airmen 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arlie Smith Bey Tyson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1776 Sea Pine Circle Severn MD 21144 Almeretta Tyson Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Atlantic Crem 1 Burial 2 Acremation 3 Removal from State 11/10/12 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv Signature of Fineral Service Licenses ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Fent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last the burial-tra Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be to within 24 hours after death.

To the Funeral Director: Advantage to the Funeral Director: Advantage to the Funeral Director: Advantage to the Funeral Director: Advantage to the Funeral Director: Advantage to the Funeral Director: Advantage to the Funeral Director: Advantage to the Funeral Director Advantage to the Funeral IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Unknown g Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed nois m 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 XNo Hospital: 1 Yes မ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06,20 MY KUNNI E 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1406 Mar 31. Date filed (Month, Day, Year) State

Registrar

12-08508 John Arthur Vargas Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1- For S Registr			Cert	tificate of	Death		Re	eg. No.	2 01010
Physician	1. Dec	edent's Name (First, Midd	lle,Last)	1			;- <u>2,-</u> ;;;	2. Date of Dea	th	3. Time of Death
edical Examine	_00		Vargas		IAI	n City Town	or Location of Dea	November	7 9, 2012 4c. County of Dea	1450 hrs
		9 Bouchelle Road	on, give saeet and number)		4	North Eas		assi	Cecil	aur
Funeral	5. Soci	al Security Number	6. Sex 7. Age	(In yrs. la	st birthday)	If Under 1 Ye			th (MM/DD/YYYY) 9. I	Birthplace (State or eign
Director		5-17-1901	1XM 2F	4	5 Yrs.	Months Da	ys Hours N	06/15	/1967	Country)California
ku#	Usual I	Residence of Decedent ate 10b. County	I	10c. City, 7	Town or Location	n				10d. Inside City Limits
Maryland 28a-f shrw any d at once.	5 1	4D Ceci	il	Elk	ton					1 Yes 2 No
the Maryland n nr 28a-f sh tiffied at once	10e. S	reet and Number				10f. Zip Code		1	0g. Citizen of What Co	ountry?
ith the 23a ur nutifie		Bouchelle				21921			U.S.A.	
items	11. Ma	rital Status Never Married 2 💢 M	12. Was Decedent I Armed Forces?	_			lispanic Origin? (an, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Race - Am White, etc.	erican Indian, Black,
		Widowed 4 Div	Vorced If Yes, Give Year	<u> </u> No	1 🔲	Yes 2X	lo specify:		Specify: W	nite
hours:			ecify only highest grade com				ation (Give kind of fe, DO NOT use r		16b. Kind of Busines	s/Industry
5-0036 ed within 72 hour tygiene. other than "natu		ientary/Secondary (0-12)	College (1-4 or 5	+)	Carpe	ntor			Const	cuction
5-00 led wit fygien other	17. Fat	ner's Name (First, Middle	, Last) Unknown		Carpe	-11661	18. Mother's Nar	me (First, Middle, I		Unknown
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica										
Shoul and M	•	ormant's Name/Relations	gas / Spouse						nber, City or Town, Sta MD 21921	ate, Zip Code)
e, N 1 and 2 Health item 3	20a. M	ethod of Disposition			lace of Disposit	ion (Name of c		Date	20c. Location - City	or Town, State
Pages ent of int: If	_	Burial 2	n 3 Removal from Sta	.0	rematory or other atomy Gif	, ,	try	/19/2012	Hanover,	Maryland
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Menlal Hygiene. Important: If item 27 is marked other than "natural?, injury ar other traumatic event, the Medical Examiner. To Re Completed by		nature of Furneral Service		11,0	22. Na	me and Addre	ss of Facility	Anatomy G	ifts Regis	stry
	23a P	art I Enter the disease of	complications that caused t	he death I						MD 21076 Approximate Interval
Physician /Medical	fa	lure. List only one cause	on each line.							Between Onset and Death
Examiner		ate Cause (Final disease lition resulting in death)	Due to (or as a conse					, 11100111		
		ntially list conditions, eading to immediate	b. Due to (or as a conse	nuence of\						
ted Insit Examine	cause. (Disea	Enter Underlying Cause se or injury that initiated	C.							W.
d ansit		resulting in death) Last	Due to (or as a consect d.	quence of)):					
760, icate be executed physician and the burial - transit	X	▼ UNPENDED								
760, icate be physical the buri		ALE: s decedent pregnant in t	23c. If yes, outcom	e of pregna	_				23d. Date of deliv	•
P.O. Box 687 that the death certific ned by the attending I detached for use as tl by Physician/	pa	t 12 months?	1 Live birth 4 Pregnant at t	ime of dea	th -	al death 3 er (Specify)	Ectopic preg	nancy	Month	Day Year
BO) he deatl the att hed for	1 1		known 9 Unknown							
signed by a detache		Other significant condit	tions contributing to death				given in Part I.			to the cause of death?
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e law r e has b ge 2 sh	<u> </u>							autop perfor	rmed? death'	
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Vital hysician this certical directors	5 Ava	miner?	Hospital: 1 Inpatier	nt 2 🔲 E	ER/Outpatient	3 DOA	Other Nur	sing Home 5	Residence 6 🗸 Ott	ner: Scene
)	Yes 2 No			001 T: (1)	ury 28c In	ury at Work?	28d. Describe	now injury occurred	
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Sion of Attending Pl r death. cctor: After by the funera	27 Mai	ner of Death Natural 5 Pend Accident Inve	ding stigation 28a Place of Injur	-12	fd 1430	hrs 1	Yes 2 No		t took dru	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas Η. Wa11 2012 9:50 A M November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlestown Care Center Catonsville Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours Director 476-03-2073 1 🛛 M 2 🗆 F 96 26, 1916 Minnesota or 28a-f show 10b. County 10c. City, Town or Location Director Maryland 1 ☐ Yes 2 🛣 No Baltimore Catonsvile 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 709 Maiden Choice Lane, RGS413 21228 United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 X Yes 2 No 1942 Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White -19463 ¥ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education. 16b. Kind of Business/Industry (Specify only highest grade completed) Mental Hygiene. arked other than Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Chemical Engineer 3M Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Wall Frances Thomas Moffet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 Ann M. MacKay / Daughter 717 Maiden Choice Ln., Apt. 511, Catonsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. 11/17/2012 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Mary and Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ obstructure hronic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in modals cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Disk to (or as a consequence by and the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy death? Yes 20€ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 20 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Vursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Accident
Suicide 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar Betterrid CENP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ann Butkrwoth

709

29c. License number

R082382

Maidwhaice (one Baltmer, Md 21228

29d. Date signed (Month. Day, Year)

11-16-12

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #26 Per PHY G933 I 1/20/2012 Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 15 2012 Physician/ Wade Hampton 1340PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE AGNES HOSPITAL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 10-06-27 6. Sex **Funeral** 9. Birthplace (State or Foreign Hours Country) 415-26-5045 Director 1**X** M 2 □ F 85 TN Usual Residence of Decedent 28a-f show 10a. State 10h County at 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No MD NA Baltimore o 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a 2 N. Smallwwod Street 21223 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. African ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", XX Widowed 4 Divorced American Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. other than " College (1-4 or 5+) NA Elementary/Secondary (0-12) Bethelhem Steel Co. 12th Grade Welding Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Ella Malone and 2 should be Health and Menta Wade, Jr. Hampton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trau 1149 N. Stricker Street Baltimore, Maryland 21217 Wayne E. Wade-Son 20b. Place of Disposition (Name of cemetery, crematory or other place, Garrison Forest 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12-03-12 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wylie Funeral Home P.A. grole 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ORONARY A RIER disease or condition resulting in death) Medical Examiner ARPIOMYOPATH Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) death certificate be executed SPHYTHMIA burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 N Vital the Hospital or Attending Physician: 25. Was case referred to medical Be xaminer? 26. Place of Death (Check only one) Other 2 🗌 No 1 Inpatient 2 ER/Outpatient 3XXD0A 은 Nursing Home 5 Residence 6 Other (Specify, funeral (Division of Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Construction of the basis of my knowledge, death occurred at the time. Unlike and place, and due to the cause(s) and manner stated. 29a Certifier (Check 29b. Signature an ATTENDING PHYSICIAN 29d. Date signed (Month, Day, Year) NOVEMBER 15 20 P UNIVOF MARYLAND SOM person who completed cause of death (Item 23a) (Type, Print) 110 S. PACA STREET BALTIMORE MD 2/201 BENJAMIN J. State 31. Date filed (Month, Day, Year) Registrar's Signature NOV 2 0 2012 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Williams 0336 Medical 2012 4a. Facility Name (it not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Hospital Cheverly Prince George's Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Director 218-46-9996 1 🛛 M 2 □ F Yrs. 65 July 14, 1947 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Prince George's Landover ₫ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7801 Balowe Road #108 20785 USA 12. Was Decedent Ever in U.S. Armed Forces? 196 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1965 Black, White, etc. 1 Never Married 2 Married β Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 1968 If Yes, Give 3 ☐ Widowed 4 🔯 Divorced Specify: Completed **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Paramedic Government other treumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur L. Williams Mary P. Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health <u> Shontell Williams/Daughter</u> <u>7905 Roxbury Court Landover, </u> MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 e Department of H Importent: If ite eny injury or ot Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 11-27-2012 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Function Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 7474 Landover Road, Hyattsville, MD 20785 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a, Part 1 shock, or heart failu Immediate Cause (Final Onset and Death Physician/ -atal disease or condition resulting in death) ardia Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Exam or Attending Physician: The lew requires that the deeth certificate be executed Cause (Disease or injury siclen and buriei-trens that initiated events resulting in death) Last Due to (or as a consequence of): ettending physiclen for use es the burie Physician/Medical Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Day the e P.O. been signed by t should be detect Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, pege 2 s autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔀 No 24 hours after deeth.
Funerel Director: After this certific letely filled in by the funeral director. **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

State

29b. Signature and title of certifier

DR. Ward R. Warren

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

DHMH 17 Rev 06-2011

DO071741

29d, Date signed (Month, Day, Year)

2012

1151

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Booker Virgil Wa		ngton, Jr. S 1-For State Registrar	tate of Maryla		artment e e <i>rtificate</i> e		and	Mental H		Reg. No.	2011	2 3737
Physicia	an/	Decedent's Name (First, Mide							2. Date of Dea Month	Day	Year	3. Time of Death 2154 hrs
Medical Exami	ner	Booker Virgil 4a. Facility Name (if not instituti	. Washingto on, give street and nu	on Jr.		4b. City, Tov	vn, or Lo	cation of Death	Novembe		County of Death	
1		4735 New Kent Drive				Upper N	Marlbo	ro		Pri	ince George	e's
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	\rightarrow	If Under 24Hrs	_	irth (MM/DI		thplace (State or
Director		489-48-3056	1XM 2F		66 Y	rs.	Days	Hours Min	09/09	/1946	5 Co	mMissouri
any		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	ation						10d. Inside City Limits
			e George's		er Mari							1 Yes 2 No
Aaryland 28a-f show 1 at once	cto	10e. Street and Number	0 000180	у Горр	CI Hai	10f. Zip Co	ode		T	10g. Citize	en of What Cou	ntry?
ith the Maryland 23a or 28a-f sho	<u>i</u>	4735 New Kent	Drive			2077	2			USA		
th with	Funeral Director	11. Marital Status 1 Never Married 2 X	12. Was Dec	edent Ever in lorces?				nic Origin? (S lexican, Puerto	pecify Yes or No Rican, etc.)		4. Race - Amer White, etc.	ican Indian, Black,
er deal			1 X Yes	2 No	1,5	Yes 2 X	No s	enecify:		l _s	pecify: B1	ack
hours after death with the Maryland 'natural', or items 23a or 28a-f she Easmiger must be notified at once	d b	15. Decedent's Education (Sp	vorced If Yes, Give Yea or Dates: ecify only highest grad			ent's Usual Oc	cupation	(Give kind of			nd of Business/	Industry
6 72 ho	Completed	Elementary/Secondary (0-12	College (1	-4 or 5+)	during	most of working	ng life. D	O NOT use ret	ired)			
within piene.		17, Father's Name (First, Middle	2YRS	5	Weapo	ons Saf		Inspec	tor (First, Middle,		overnme	nt
21215-0036 uld be filed within 72 Mental Hygiene. marked other than 'c event, the Medical	BeC	Booker V. Was	•									
212 buld bould b	10	19a. Informant's Name/Relation		•	19b. Mail	ng Address (<u>nnice H</u> Rural Route Nu			, Zip Code)
nore, MD 21215-0036 sges I and 2 should be filed within 72 rt of Health and Mental Hygiene. It: If item 27 is marked other than "other traumatic event, the Medical		Debra Washingt	on/Wife						Upper	Mar11	oro, M	D 20772
		20a. Method of Disposition 1 XBurial 2 Crematic	n 3 Removal fro		. Place of Disp crematory or		of cemet	tery,	Date	20c. Lo	cation - City or	Town, State
Baltimore, permit. Pages I ar Department of Hec Important: If ite		4 Donation 5 Other 5	pecify:	Ar	lington	Nat'l	Cen					, V <u>irginia</u>
Baltimo permit. Page Department of Important: injury or oth	ļ	21. Signature of Funeral Service	Licensee		22			0.				Home, Inc. D 20785
Physician	\dashv	23a. Part I. Enter the disease, o		aused the deat	h. Do not ente	the mode of o	lying, su	ch as cardiac	or respiratory ar	rest, shock	k, or heart	Approximate Interval
/Medical. Examiner		failure List only one cause Immediate Cause (Final diseas	I be seen and a security	e Atheros	clerotic Car	diovascula	r Disea	ase				Between Onset and Death
Adminier		or condition resulting in death)	Due to (or as a	consequence	of):							
	-	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	consequence	of):							
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ansit	Exa	events resulting in death) Last	d.	consequence	Of):							
50, te be executed ysician and burial - transit	edical	UNPENDED	AMENDED					1				
6876C certificate nding phys	/Me	IF FEMALE: 23b. Was decedent pregnant in		outcome of pre		etal death	3	Ectopic pregna	ancv		Date of deliver	/ Day Year
Box 6876(e death certificate the attending physed for use as the b	Physician/M	past 12 months?	4 Pregn	ant at time of o	tooth -	Other (Specify						,
b.O. Bo) that the death ned by the att detached for	hys.	1 Yes 2 No 9 Ur Part II. Other significant condi	tlone contributing to		reculting in the	underlying	uso sive	on in Bart I	23e Did 1	ohacco us	se contribute to	the cause of death?
, P.O. res that th signed by be detach		Chronic Alcohol Abu			resulting in the	dilderlying Ca	iuse give	minirali.	1 ✓ Ye			pably 4 Unknown
ords, aw require as been sig	eted								24a. Was			topsy findings available
Division of Vital Records, P.O rate a Attending Physician: The law requires that transfer death. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be dear	Completed by								auto perfo 1 ✔ Yes	ormed?	death?	completion of cause of
tal Reco	Be Co	25. Was case referred to medic	al			26.	Place of	Death (Check		2 140		2 140
Vital I hysician: this certifi ul director,	E B	examiner? 1 Yes 2 No		npatient 2	ER/Outpatie		`		ng Home 5		ce 6 🗸 Othe	r; Scene
ding Ph		27. Manner of Death 1 ✓ Natural 5 Per	28a. Date (Month,	of Injury Day,Year)	28b. Time o	f Injury 28c		at Work?	28d. Describe	how injury	y occurred	
ivisior or Attend after death Director:	icati	2 Accident Inve	estigation 28e Place	e of Injury - At	home, farm, str	eet, factory, of			28f. Location (Street and	Number or Ru	ral Route Number, City
Divisi spital or Ath hours after d meral Direct y filled in by	Certification:		Ild not be crmined (Specify)	,		,,			or Town,			,
2 - = > 1		29a. Certifier 1 CertifyIng F	hysician: To the bes									
To the Ho within 24 To the Fu completed	Medical	29b Signature and title of certif	and manner s		and/or investig		icense n		at the time, date		ate signed (Mo	
		D. A	- Pa	00.			C.M.				mber 5, 20	
	}	30. Name and address of perso	n who completed caus	e of death (Ite	m 23a)							
		Patricia Aronica-Polla			Examiner		Baltimo	re Street, E	Baltimore, M	ID 2122	3	· · · · · · · · · · · · · · · · · · ·
St Regist		31. Date filed (Month, Day, Year, NOV 2 0		gistrar's Signa	. par	Ked						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Williams 4:25 PM David 2013 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Battimore If Under 1 Year I If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Director 1 NM 2 F 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 21th more 1 ☐ Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Armed Forces Black, White, etc. "natural", or ò 1 Never Married 2 Married √Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 - Widowed 4 - Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Unk 18. Mother's Name (First, Middle, Maiden Surname) ڡ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trains ynne 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State cemetery, crematory 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Ligense 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such in cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Multifoca Onset and Death Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying
Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Day page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Mellitus Division of Vital Records, Hypertension, Diobetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of autopsy 1 ☐ Yes 2 🗷 No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours To the Funeral Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number NPI: 1093030553 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Greene Street vartuccio Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

X DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17.19b Per PH C934 12/18/2012 III amend #17.19b Per PH C934 12/18/2012 III amend Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PAULINE WELSH Medical NOVEMBER 3:00A 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CHESTERTOWN NURSING AND REHABILITATION CHESTERTOWN KENT 5. Social Security Number Funeral If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 9. Birthplace (State or Foreign Davs Director 212-78-8119 1 🗆 M 2 🗶 F Usual Residence of Deceder 94 12/20/1917 MARYLAND 28a-f shov th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10b. County **Funeral Director** 10c. Cify, Town or Location 10d. Inside City Limits MD CARROLL 1 Yes 2 No MOUNT AIRY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 MERRY GO ROUND WAY 21771 UNITED STATES filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last)
Arthur Fred Will 18. Mother's Name (First, Middle, Maiden Sumame) ည and 2 should be LEROY FRANCIS WELSH RENIE BUCKINGHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code)
709 Merry Go Round Way Mt Airey MD 21771
3860 HOOPER ROAD NEW WINDSOR, TARYLAND 21776 f Health aitem 27 i other CHARLOTTE TWENTY / DAUGHTER 20a. Method of Disposition Department of H Important: If ite any injury or oth once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 20c. Location - City or Town, State 1 🔀 Bunal 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Olive Cemetery 11/20/2012 Mt. Airy, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND went Mars 23a, Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached f Month 1 Yes 2 No Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 🗆 Yes 2 No 3 Probably 4 Unknown ranom 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 00 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 1 🗌 Yes 2 No.No ျှ Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation М 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) V rson who completed cause of death (Item 23a) (Type, Print) 32. Registraria Signature

Registrar DHMH 17 Rev 06-2011

State

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER Day 5 01:45PM 2012 KENNETH EUGENE WARS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) 214-46-5056 Director 1 M 2 □ F 5 - Mary land 11-17-1945 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director en "natural", or Items 23a or 28a-f s Medical Examiner must be notified 1 X Yes 2 ☐ No MD Prederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Hillmeade Square 21702 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) Govit Plumber th and Mentai Hygle 27 is marked other treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Hyland Elmer Wars Francis Ingram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederich Mts 21701 Arlene Wars 1776 Hillmeade Square 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pege 1
Department of I
Important: If it
any injury or or 1 Surial 2 Cremation 3 Removal from State 11-24-2014 Frederick MD Resthaven 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 110 W South St PO BOX 3500 22. Name and Address of Facility Yan Gary L Rollins Figural Home Frederick MD 21705 23a. Part 1. Enter the sease, or conshock, or heart failure. List only pase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Ooset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ZII S Medical Due to (or as a consequence of): Examiner MOYIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine After this certificate hes been signed by the ettending physicien and funerel director, page 2 should be deteched for use as the burlai-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Box 68760 If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Pregnant at time of death 0.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Certificate: To Be Completed 1 ☐ Yes 2 😿 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funerel director, I of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Doubth 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 5 Pending Division 2 🗌 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The defical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year) 12 NOV 2 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month FRANCIS T. WEBER JR. 2012 8:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GILCHRIST TOWSON BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months (Month, Day, Year) Director 219 16 6640 1 X M 2 □ F Yrs 87 2/6/1925 MD Usual Residence of Decei er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD 1 X Yes 2 ☐ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5717 NEWHOLME AVENUE 21206 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: 3 √ Widowed 4 ☐ Divorced Specify: WHITE ear or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 YEARS MACHINIST O'BRIENS MACHINE SHOP Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even FRANCIS T. WEBER SR. BERTHA WOJCIK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHLEEN KREUL (DAUGHTER) 2600 JERALD DRIVE PARKVILLE, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 11/20/2012 ROSEDALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME 6415 BELAIR RD BALTIMORE, MD 21206 23a. Pan 1. Enter the discussion or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, since k, or heart failure. List only one cause on each Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a nsequence of): Examiner MC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to ar as a consequence of): Cause (Disease or injury for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): ettending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Day Year To the Funeral Director: After this certificate has been signed by the e completely filled in by the funeral director, page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed's 2 🖼 No Yes 2 No 1 🗌 Yes Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certifical Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Unique Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title ø 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NCI 6710 KUMA 32. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 2 0 2012 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 📦 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November am Franklin D. R. Williams Medical 4a. Facility Name (if not institution, give street and number City, Town, or Location of Death 4c. County of Death **Examiner** Maryland General N/A 24 Hrs.V ge (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Months Days Hours Min. (Month. Dav. Year) Director <u> 238-58-6333</u> NC Oct 21, 1937 Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 XYes 2 No MD **Baltimore City Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2944 Carver Road 21225 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No Completed by Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) **Pastor** Christian Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Willie Williams **Essie Lee Williams** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaFranze Williams-Fooks 2944 Carver Road Baltimore, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ■ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, ☐ Donation 5 ☐ Other (Specify) Nov 21, 2012 Jackson, NC Roanoke B C Cemetery 21. Signature of Funeral S rice Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that causes shock, or beart failure. List only one cause on each line. or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician/ Medical resulting in death) ue to (or as a con quence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner greatory Farlure status post Michanial Ventilation attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the i Unknown g Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 : this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation after death 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) filled in 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho
To the Fune (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 11/14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar Signat State NOV 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 16, 2012 Physician/ Month Bette Lynn Willis November 0830 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Apr 5, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1946 Director 1 □ M 2 🖳 F Pennsylvania 215-46-2719 66 or than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health end Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Ite Medical Examiner must be notified at ury or other traumatic event, Ite Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 0f. Zip Code 10g. Citizen of What Country? Funeral 3807 Gawayne Terrace 20906 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. Š 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Bank Teller Financial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gerald Wesley Sheerer Marjory Brooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3807 Gawayne Terrace Silver Spring, MD 20906 19a. Informant's Name/Relationship (Type, Print) Loraine Patterson / daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
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once. 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) inal Journey Crematory 11/21/12 Woodbine, MD Signature of Juneral Service Licensee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cays Immediate Cause (Final Physician/ disease or condition resulting in death) Sersis Medical Due to (or as a consequence of): Examiner days Fever Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been sinned by the control of days Pneumonia attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus Type II 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 2 XNo erel Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Tes 2 🔯 No မှ 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nume Practitioner: To the best of my knowledge, death occurred at the films, date and place; and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signatury 29c. License number 29d. Date signed (Month, Day, Year) D32332 11-16-12 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Suresh K. Gupta 9801 Georgia Ave. Suite 220 Silver Spring, MD 20902

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 18, 2012 1:25 p de Forest Webster Henry Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Cockeysville Broadmead Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours Min. (Month, Day, You New York Director Apr 030-28-0850 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Examiner must be notified or 28a-f 1 Yes 2 X No Cockeysville MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral items 23a 21030 USA 13801 York Rd. #N4 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. o, ģ 1 Never Married 2 Married If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: White 3 □ Widowed 4 □ Divorced "natural" Completed 1944-46 the Medical Baltimore, Maryland 21215415. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Neuropathologist Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Emily Johnston de Forest Leslie Tillotson Webster permit. Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2475 Virginia Ave. NW #729 Washington, DC 20037 Christopher White Webster/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 11/19/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Going Home Cremation Service P.O. Box 784 Heckrotte, P.A. Clarksville, Beverly L. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. set and Dea Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) and -transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day Pregnant at time of death 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de þ the Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Deat heck only one) examiner? Hospital: 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 U Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier and address of person who completed 80 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

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Maryland 21215-0036	permit, rage I am a should be hed whinh I be permit and I health and Mental Hygiene. Importent: If item 27 is marked other than any Injury or other traumetic event, I'm Mone.		19a. Informant's Name/Relationsl Howard C. Woods		husband						Route Number				Code)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 03:37p M Wells Sheila Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Towson Gilchrist Hospice Care Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days (Month, Day, Year) Director 85 215-66-0475 1 🗆 M 2 🕱 F Trinidad Yrs 02/15/1927 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Trinidad 21214 2500 College Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify If Yes. Giv 3 X Widowed 4 Divorced Specify: Completed Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Bonhomme Augustine Jerome Eliza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2500 College Avenue BAltimore, MD 21214 Annmarie Wells, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State San Fernando Trinidad Page 1 Department of I Important: If it any injury or of 1 D Burial 2 D Cremation 3 🔀 Removal from State Unknown 4 Donation 5 Other (Specify) Marabella Cemetery Leonard J. Ruck, Inc. 21214 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 5305 Harford Road, Baltimore, MD Japanaria 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancon Physician/ east disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Cother (Specify) [교 1 ☐ Yes 2 No alson dean.
rai Director: After time.
by the funeral di 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury 1 Natural 2 Accident 5 Pending injury Work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a
To the Funeral D
completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year) We'll Jes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Touson MO Charles

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11/14/2012 Reginald C. Young 6:42 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3330 Buffalo Rd. New Windsor Carroll 5. Social Security Number 7. Age (In yrs. last birthday, If Under 24 Hrs Hours Min. Birthplace (State or Foreign Country) Date of Birth **Funeral** (Month, Day, Year) Director 1XXM 2 ☐ F 218-05-1350 93 8/25/1919 MD er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at e 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show ir other traumatic event, the Medical Examiner must he notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3330 Buffalo Rd. 21776 USA 11. Mantal Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Specify. **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) City of Elementary/Secondary (0-12) College (1-4 or 5+) Sanitarian Philadelphia Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Russell W. Young Lillian Austin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginald C. Young, Jr./Son 3330 Buffalo Rd., New Windsor, MD 21776 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Denation 5 Other (Specify) Carroll Crematory 11/16/2012 Winfield, MD 21. Signature of Funeral Service Licens ²² Burrier Queen Funeral Home & Crematory, P.A. Old Liberty Rd., Winfield, MD 23a. / art 1 Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line Interval Between Immedia - Cause (Final disease / r condition r sulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): eral Director. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury tten ing Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68766 that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 2 No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ Completed 1 Tes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 100 ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital or 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Hosp within 24 hou To the Funer completely fi 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:24AM ARCHER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRINCE GEORGE'S LANHAM DOCTORS HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Director 149-14-7685 1 M 2 XF Yrs Aug. 31, 1911 NY 101 works 10b. County than "natural", or items 23a or 28a-f sho he Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 K No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20716 3850 Enfield Chase Ct. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Examin 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Black Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private 12th Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Effie Douglas Curtis Ralph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2024 36th St. SE Washington, DC 20020 Paula Bennett - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 【X Cremation 3 ☐ Removal from State Metropolitan Crematory 10-29-2012 Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Marshall-March Funeral Home of Maryland
4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Gastrantutina Medical resulting in death) Examiner Unknow, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and I for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month Year been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an cate has t ; page 2 s autopsy performed death? this certificate within 24 hours after death.

To the Funeral Director: After this certific, completely filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 No 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 043446 10.25.12 SM

Registrar DHMH 17 Rev 06-2011

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Glendle MO 20769

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's

Annapolis

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ September Day 16, 2012 6:23 Jeffrey Lewis Alexander Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6410 Governers Square Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/10/1958 9. Birthplace (State or Foreign Country) Maryland **Funeral** 7. Age (In yrs. last birthday) Days Hours 220-68-8888 54 Director 1 ☐ M 2 ☐ F 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County th and Mental Hygiene. 27 is marked other then "neturel", or items 23a or 28a-f sho traumatic event, the Madical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6410 Governers Square 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Completed White 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5 Vice President Steel Products Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Karl Alexander Yvonne Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Rebecca T. Alexander / Spouse 6410 Governers Square, Salisbury, MD 21801 20a. Method of Disposition
1 ☐ Burial 2 🍎 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: if it eny Injury or o cemetery, crematory or other place)
Salisbury Crematory 09/18/2012 4 Donation 5 Other (Specify) Salisbury, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd.. Salisbury. MD 21804 Crompron CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ 14mo Okh Medical resulting in death) Due to (or a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Universitying Examine Due to (or as a consequence of): ettending physicien end for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 No After this certificate has been signed by the of the retaineral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural Accident 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box 68760 Division of Vital Records, P.O. To the Hospital or Attending Physicien: I within 24 hours after death.

To the Funerel Director. After this certifics completely filled in by the funeral director, I

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OF STA 31. Date filed (Month, Day, Year) State 32. Registrar's Signatu Registrar

Medical

29a. Certifier

(Check only one) 29b. Signature and title of ce

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

262

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death ^{Day} 20<u>12</u> Month OCt. Physician/ Theresa G. Brown 31 0420 М Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Callaway Hospice of St. Mary's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) 214-32-9962 Director 1 DM 2 DXF 75 Yrs 11/11/1936 MD permit. Pega 1 and 2 should be flied within 72 hours efter deeth with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23s or 28e-1 show any injury or other traumetic event, the Medical Examiner must be notified at 2008e. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Lexington Park MD St. Mary's 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21895 Pegg Road Unit. 232 20653 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc Completed by 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify: If Yes, Give 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) School Bus Driver/Janitorial School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence Chase Samuel Day 19a. Informant's Name/Relationship (Type, Print) John Legrant/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22920 Town Creek Dr. Lexington Park, MD 20653 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St. Peter Claver Ch.Cem. 11/10/2012 4 ☐ Donation 5 ☐ Other (Specify) St. Inigoes, MD 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature Tuneral Service License 2294 Old Washington RD Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician disease or condition Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ed by the ettending physicien and deteched for use as the buriel-transit or Attending Physicism: The lew requires that the death certificets ba executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) Month signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown this certificate has been si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA tor; After this / the funaral d 28a. Date of injury (Month, Day, Year) 27. Manner of Dear Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be To the Hospitel or Atta within 24 hours effer de To the Funeral Directo compistely fillad in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, *0*/2

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of

Callaway, MD

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rson who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Schmidt 44724 Hospice In

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:55 AM McMorris Bassett Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Regional Medical Center Salisbury Wicomico Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Director 218-48-5386 1 | M 2 | X F 66 7-6-1946 Washington, DC permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Importent: If item 27 is merked other then "natural", or items 23e or 28e-f show amy injury or other treumatic event, the Mastel Examiner must be notified at once. 10a State 10b. Count 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 ☐ No Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 519 Clyde Avenue 21826 USA 11. Marital Status Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Force Black, White, etc. \$ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify Specify: Completed 3 Widowed 4 N Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Title Company Mortgage Processor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ McMorris George Louise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Bassett - Son 519 Clyde Avenue, Fruitland, Maryland 21826 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 10-2-2012 Delmar, Delaware 21. Signature of Ineral Service License 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, of shock, or heart failure. List lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) NSTEMI Physician/ Medical Due to (or as a consequence of): Examiner failure Rena hronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ettending physicien and I for use es the burlal-transit or Attending Physicien: The law requires thet the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) after death. Director: After this certificate has been signed by the e d in by the funeral director, page 2 should be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes 2 X No ٩ 1 M Inpatient 2 ☐ ER/Dutpatient 3 ☐ DDA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital c within 24 hours at To the Funerel D completely filled i Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated The deficial Examiner: Do the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 10-01-2012

No 4

DHMH 17 Rev 06-2011

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

rz-06134 Feresa Ann Bass	5	State of Maryland / Department o			gible.	
		1- For State Certificate o		7.0	eg. No. 201	2 3739
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle,Last) Teresa Ann Bass		Date of Deat Month	h Day Year	3. Time of Death
- Adding Example		4a. Facility Name (if not institution, give street and number) Civista Medical Center	4b. City, Town, or Location of La Plata	October 2	4c. County of Deat	2037 hrs
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under	24Hrs. 8. Date of Bin	th (MM/DD/YYYY) 9. Bi	rthplace (State or
Director		062-68-8639 1 M 2 ★ 40 Yrs	Months Days Hours	Min. 10/2	8/1971 Forei	gn puntry) NY
v any	Ì	10a. State 10b. County 10c. City, Town or Locat	ion			10d. Inside City Limits
aryland 82-f show	ট্ৰ	MD Charles Waldor				1 X Yes 2 No
21215-0036 Mental Hygiene marked other than "matural", or items 23a or 28a-f sho revent, the Medical Examiner, must be notified at once.	Director	10e. Street and Number 6223 Kodiak Bear Court	10f. Zip Code	10	ng. Citizen of What Cou	ntry?
with th			20603 Is Decedent of Hispanic Origin	? (Specify Yes or No-	USA 14. Race - Amer	ican Indian, Black,
death or iten	Funeral	1 Never Married 2 Married Armed Forces? If Y	es, specify Cuban, Mexican, F		White, etc.	
rs after ural",	اھ	t of Dates.	Yes 2 No specify:P		Specify: Hisp	*
5-0036 Hed within 72 hours Hygien 72 hours Outher than "natur	Completed		ost of working life. DO NOT us		16b. Kind of Business/	Industry
within sene.	Ē		urse		Private	
21215-0036 uld be filed within 7 Mental Hygiene event, the Medica	Be င၀	17. Father's Name (First, Middle, Last) Cesareo Mendez		Name (First, Middle, M a Rodriqu		
2121, ould be fill Mental H marked ic event, t	9		Address (Street and Number	_		, Zip Code)
imore, MD 2 Pages 1 and 2 shou ment of Health and I ant: Utien 27 is or other traumatic			Kodiak Bea			
Ore,		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Dispos	· · · · · · · · · · · · · · · · · · ·	Date	20c. Location - City or	
Baltimore, permit. Pages 1 at Department of He. Important: If ite injury or other tr	1	4 Donation 5 Other Specify: Holmdel C	Cemetery lame and Address of Facility		Holmdel, N	
Depa Depa In po			94 Old Washington		ic Funeral Hon	æ
Physician	1	23a Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	ne mode of dying, such as card	liac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a Multiple Gunshot Wounds				. Death
.ed		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
	힐	if any, leading to immediate Due to (or as a consequence of):				
g. g	탈	(Disease or injury inat initiated events resulting in death) Last Due to (or as a consequence of):				
= 5 4	- -	d.		 		_
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687 Sertifica Iding p		3b. Was decedent pregnant in the past 12 months?	al death 3 Ectopic pr	regnancy		ay Year
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Fugure death. To the Fugure and Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bunical completely filled in by the funeral director, page 2 should be detached for use as the bunical control of the funeral director of th	Pnysician/med	1 Yes 2 No 9 V Unknown 9 Unknown	ner (Specify)			
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ords, P.C. w requires that s been signed t should be deta				1Yes 24a. Was ar	2 No 3 Prob	
of Vital Records, is Physician: The law require ther this certificate has been sineral director, page 2 should be a Committed.	Completed			autops	y prior to c	topsy findings available ompletion of cause of
tal Rec	3	25. Was case referred to medical	26.Place of Death (Ch	1 ✓ Yes 2	No 1 ✓ Ye	s 2 No
F Vital Physician: er this certif ral director,	ŏ٠	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient	[Other =		esidence 6 Other	
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Division tall or Attendii sa after death. al Director: / led in by the fi	<u> </u>	2 Accident Investigation 28e Place of Injury - At home farm street	1 Yes 2 V No	U-2		al Paula Number 6th
Division o spital or Attending nours after death. neral Director: Aft filled in by the fune		3 Suicide 6 Could not be determined (Specify) Other (specify)	t, ractory, office building, etc.	or Town, Sta	reet and Number or Rur ite) School, Waldorf, MD	
E Hosp 24 hor E Fune etely fi		9a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr	ed at the time, date and place,	and due to the cause	(s) and manner as state	d.
To the Howithin 24 h To the Furcompletely		2 Medical Examiner: On the basis of examination and/or investigation and manner stated. 9b. Signature and title of certifier				
	[A see Africally 11 20 A	29c. License number O.C.M.E.		29d. Date signed (Mon October 27, 2012	
	3	0. Name and address of person who completed cause of death (Item 23a)				
pr		Pamela E. Southall, MD Assistant Medical Examiner 900	W. Baltimore Street, B	altimore, MD 212	223	
Stat	e 3	1. Date filed (Month, Day, Year) 2012 32. Legistrar's Signature	Kel			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. lend #205 Per FH G933 11/20/2012 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day}4 OCTOBER 2012 GEORGE ANTHONY BOLTON 12:25P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs.

Manthe Days Hours Min. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) Director 263-68-0485 1 M 2 □ F 71 Oct. 8. Usual Residence of Deced ir then "neturel", or Items 23a or 28e-f show the Mode. I Expriner must be notified at 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10d. Inside City Limits MD 1 Yes 2 No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7196 Allegheny Dr. 21702 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed Specify: 3 Divorced 4 Divorced Year or Dates white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 end 2 should be filed within 72 ment of Heelth and Mental Hygiene, ant: If item 27 is marked other then Elementary/Secondary (0-12) College (1-4 or 5+) 5+ technical manager industrial roofing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William E. Bolton Mary Lee Roberts-Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Bolton/wife 7196 Allegheny Dr., Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/2972012 Important: If it eny Injury or o once, 1 Burial 2 D Cremation 3 Removal from State Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) $\frac{10/29/31}{}$ Frederick, MD Signature of Funeral Service Lipenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disea shock, or heart failure List or Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ncrea Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause Extending to immediate Cause (Disease or injury Examine Due to (or as a consequence of) ed by the attending physician end detached for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day 9 Unknown ate has been signed by I page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has t autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in accordance to the cause of examination and/or investigation in accordance. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rai 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 0/23 7201 Zear 2:35 a M Maurice Α. Bushrod /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hyattsville Prince Georges St. Thomas More Nursing Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 11/7/1932 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F 579441317 79 Director Virginia Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a, State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Its Modical Expriment must be netified at 1 Yes 2 □ No Director Washington D.C. 10f. Zip Code 20012 10g. Citizen of What Country? 10e. Street and Number 1763 Sycamore St. N.W. U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Des 2 □ No 1 D es 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Self Employed Elementary/Secondary (0-12) College (1-4or 5+) Bacteriologist 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Courtney Bushrod Gladys Cook ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1763 Sycamore St. NW Wash, D.C. 20012 Barbara Bushrod Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Shiloh Church Cem, 10/29/2012 Lorton, VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility P. BelleW. More 155 ette - Johnson P. A. 21. Signature of Funeral Service Licensee 2107 Carl Ct. Acco Keek, MD. 20607 23a. Part 1. Enter the disease, or complications that cause the death. shock, or heart fallure. List only one cause one ach line. Immediate Cause (Final **Physician** ard revarentery disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in dooth Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ∏Yes 2 ∏No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ notenno 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 24□No 24a. Was an autopsy perform 1 ☐ Yes Division of Vital 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes aL No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 🗌 No ours after death neral Director: / filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 0006368 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VANAUREN ST. ANNAPILIS KURUF 900 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2-08142 onathan David	Boy	Please Type or Print in Black Indelible Ink. Ensure All Copie wers State of Maryland / Department of Health and Mental Hy 1-For State Certificate of Death		gible. 2012	2 3739
Physici	an/	Registrar Certificate of Death	Reg	g. No.	3. Time of Death
Medical Exam		Jonathan David Bowers	Month October 27	Day Year 7, 2012	0425 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Peninsula Regional Medical Center Salisbury		4c. County of Death Wicomico	
Funeral Director	â	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	_	/1962 CB	
Maryland 28a-f show any d at once,	ō	Usual Residence of Decedent 10a. State		, 1302	10d. Inside City Limits
death with the Maryland or items 23a or 28a-f sho must be notified at once,	Director	10e. Street and Number 10f. Zip Code 8610 Mennonite Church Road 21871	10	g. Citizen of What Cour	itry?
	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 X Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No specify:		White, etc.	
5-0036 led within 72 hours afte Hygiene. other than "natural?, the Medical Examiner	eted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) To Dates: 16a. Decedent's Usual Occupation (Give kind of w during most of working life, DO NOT use retired to the control of the c		16b. Kind of Business/I	nite Industry
5-003(ed within lygiene. other tha	Completed	12 – Mechanic 17. Father's Name (First, Middle, Last) 18.Mother's Name	(First, Middle, M	Elevator	
2121; Muld be fill Mental F marked	Be	Charlie Morlan Bowers Kay Har			
	၉	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R			
e, M l and 2 Health ; item 2;		Amy C. Henderson/Fiancee 8610 Mennonite Churcl 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date Date	20c. Location - City or	Z18/1 Town, State
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and I Important: If item 27 is n injury or other traumatic			1/2012	Salisbur	
Balti permit. Departm Imports	10	Holloway Funeral I	, od 150	11 LIN 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Association 304
Physician	1 121	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Head and Neck Injuries Due to (or as a consequence of):			Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
cuted nd transit	I Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
iO, e be executed ysician and burial - transii	dica	UNPENDED AMENDED			
OX 6876 cath certificat e attending ph	Physician/Medical	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (Specify) 9 Unknown 9 Unknown 9 Unknown 1 Pregnant at time of death 5 Other (Specify) 9 Unknown 9 Unk	псу	23d. Date of delivery Month D	ay Year
s, P.O. E ires that the d signed by the	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	I	acco use contribute to t	
Division of Vital Records, lal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the fineral director, page 2 should be	Completed		24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of
Vital Rec ysician: The I his certificate I director, page		25. Was case referred to medical 26.Place of Death (Check o	1 Yes 2	No 1 ✓ Yes	2 No
Vita hysicis this ce	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other 4 Nursing	Home 5 R	esidence 6 Other:	
ion of tending Pheath. tor: After to the funeral			28d. Describe ho Subject assau	w injury occurred ulted	
Divising pital or At ours after deral Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify) Field 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office buildi	or Town, Star	reet and Number or Run te) Church Road-field,	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.			
	Σ	29b: Signature and title of certifier 29c. License number O.C.M.E.	j	29d. Date signed (Monitorial Control of the Control	
HBI		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, I	MD 21223		

N. State Registrar

32. Registrar's Signature

barks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #3 per med cert G934 12/5/12 dk

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 25^{Day} Month 9 201^{ear} A^{M} Wayne Ross Brown 11:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 24166 Taylor Trail Mardela Springs Wicomico Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours (Month, Day, Year) Director 217-54-6036 1 🛛 M 2 🗆 F -23-1951 61 MD or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Mardela Springs Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 24166 Taylor Trail 21837 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: special lack 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Cardista Elementary/Secondary (0-12) College (1-4 or 5+) 12 Pharmacy Pharmaceutical Tech Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary E. Dashiell Ostein Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Perrie Brown/Wife 62<u>6</u> Homer Street, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other blace) Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Cremation, 10-5-2012 Dover, DE 4 Donation 5 Other (Specify) Direct Bennie Smith 917 W. Isabella St. 21. Sign very of Funeral Service Licenses Funeral Home Salisbury MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final set and Death ₽nysician/ TON disease or condition Medical resulting in death) Due to (or as a consequence of) Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed ettending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death After this certificate has been signed by the connectal director, page 2 should be detached a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔭 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical within 24 hou To the Funer completely fil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, greatn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and add ess of berson who completed cause of death (Item 23a) (Type, Print) dx 05 31. Date filed (Month, Day, 32. Registrar's Signature State 2012 03 UUI Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2017 Phanorris V. Baines Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death VICOMIOO ENINSALA ecurity Num If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 217-84-1985 Director 49 1 □ M 2X□ F 8-8-1963 irginia 10a. State 10b. County ral", or items 23e or 28a-f sho Exeminer roust be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Somerset Westover 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 32650 Coston Road 21871 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ð 1 XNever Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. "natural" 3 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumetic event, the Be 튱 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) d Mental I ၉ George H. Baines Doris E. Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other tr Mildred Hayward/Sister Hayman Drive, Princess Anne, MD 21853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation) 5 ☐ Other (Specify) 10-27-2012 Westover, MD John Wesley Cem 22. Name and Address of Facility 917 W. Signature of Euneral Service Licenses Isabella St. Bennie Smith Funeral Home Salisbury, Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physiclen and I for use as the burial-transil Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year signed by the at 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed?

Yes 2 No certificate 2 🗌 No 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funerel Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical å 26. Place of Death (Check only one) Hospital ၉ 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AB, MD 100E 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

26 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>Bettie Jennie Brant</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Allegany WMHS-RMC Cumberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Min Director 1 M 2 F 8/14/1932 80 MD 28a-f sho 10a. State 10b. County items 23a or 28a-f sho ner must be notified at with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Allegany Cumberland 10e. Street and Number 10g. Citizen of What Country? Funeral 17 Browning St. 21502 death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Examiner Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "--any injury or other transment. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3altimore, Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Year or Dates white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 <u>homemaker</u> own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George McDonald Sadie Knepp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Brant/son Grandview Pl. Middletown, MD 2176 7803 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Donation 5 Other (Specify) Sunset Mem Park 11/3/12 | Cumberland, MD f Fun al Service 21. Signatur Scarpelli Funeral Home Ave.Cumberland, MD21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Septic Shock disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Mesentric Oschemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine 25 chemic Cardiomyopathy burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Day Year Pregnant at time of death ed by the a detached f Unknown g Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy performed 1 Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗷 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: eral Director; After I filled in by the funer 28d. Describe how injury occurred 5 Pending injury Accident Investigation 1 Yes 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30/12

State Registrar runomula

MD

12501 WillowbrodCPD Cumb, MDD1500

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2^D7 2012 CATHERINE OCTOBER ANNA CONAWAY 9:45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 20-26-0667 1 🗆 M 2 🗓 F 88 05/24/1924 Maryland 28a-f shov 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Walkersville 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Liberty Street 21793 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 lalth and Mental Hygiene. 27 is marked other than "r r traumatic event, <u>the Med</u> Elementary/Secondary (0-12) College (1-4 or 5+) Animal <u>caretaker</u> BioScience Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Lakin Mary Sigler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i Kathy Conaway / daughter Liberty St., Walkersville, MD 21793 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of I
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glade Cemetery 11-2-2012 Walkersville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 40 Fulton Ave, Walkersville, MD 21793 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ARDIOMYOPATHY Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) Exami ipital or Attending Physician: The law requires that the death certificate be executed ours after death.

Ineral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 1 Yes 2 1 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending iniury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 0061410 ess of person who completed cause of death (Item 23a) (Type, Print) TOLL HOUSE FREDERICK, MD FAR 801

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov. 2012 07:05 Kenneth Willard Cooper Medical 4a. Facility Name (if actinstitotion give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death <u>Memorial</u> Hospita] Oakland Garrett If Under 7. Age (In vrs. last birthday) **Funeral** 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F 05705/1935 236-62-1200 ORIVIY) 77 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as 10a. State Director 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 💢 No Preston Aurora 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26705 27645 George Washington Hwy. USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Completed 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry
Mettiki (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Coal Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Benjamin Eston Cooper Ethel Catherine Harper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darinda Turley/Daughter Rt.2 Box 235 Ridgeley, WV 26753 20a. Method of Disposition 20c. Location - City or Town, State Date P0h. Place of Disposition (Manuerpf Legislation of other place) 1 X Burial 2 Cremation 3 Removal from State 11/12/12 Red Creek, 4 Donation 5 Other (Specify) Cemetery Signature of Funeral Service Licensee 22. NaMoin Rivers of Willeral Home Box 186 Davis, P.O. WV 26260 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on e Interval Betwe Immediate Cause (Final Physician/ and Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by noumong 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at Natural 28d. Describe how injury occurred 5 Pendina iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Kcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Murse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 11.7.12 son who completed cause of death (Item 23a) (Type, Print)

Registrar

VAKIGAN MD 21550

311 N. 4th Street

A. Goralski MD

NOV 2 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1535 eanor amphel Medical n 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MIDICAL RPBIONAL CMIU PENINGULA HILIMICO Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min. (Month, Day, Year) 231-54-976 Director 1 M 2 M 93 -25-1919 Usual Residence of Decedent or 28a-f shov 10b. County 10a. State permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland or then "netural", or items 23a or 28a-f sho 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits MD 1 ¥Yes 2 ☐ No Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 21804 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ⊠Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker other treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ္ Marsa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) Health em 27 8 Marie 51 Daughter 21804 MD lamobell 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ò ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If eny injury or once. 4 Donation 5 Other (Specify) -a-a012 John Cemeter Temperanceville, UA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chincolegue, VA a 333L mande honeral Church 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probabiy 4 🗷 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 X the Funerei Director: After this certific mpletely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No ပ္ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury within 24 hours after death.

To the Funerei Director: Ai
completely filled in by the fu Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of a 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0, BAIDAKS 100 OHAMMAS MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Hygiene

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Rhonda Regina Dawson	State of Maryland / Department of Health and Mental
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2012 37405

		1- For State Registrar			Cer	rtificate of	Deat	th		•	F	Reg. No.		J 1 1	L 0 1 4 0
Physici		1. Decedent's Name (First, I								- 1	2. Date of Dea	ath			3. Time of Death
Medical Exam	iner	-									Month Novembe	er 10, :	2012 Year		1141 hrs
		4a. Facility Name (if not inst		street and numbe	r)		-		Location of	of Death			c. County of	f Death	
		12606 Valley View						berland					Allegany		
Funeral Director		5. Social Security Number 233–86–1913	6. Sex			ast birthday)	If Und Month	ler 1 Yea		r 24Hrs. Min.	8. Date of B	irth (MM.	/DD/YYYY)	9. Birtl Foreigi	hplace (State or
		200-1913	11	M 2 🔀 F	60	Yrs		.o Duy	110010	******	01/10	/195	2	Cou	West Virginia
A		Usual Residence of Deceder 10a. State 10b. Cou			140- O't-	Ŧ									
IW ADY			,			Town or Locat	ion								10d. Inside City Limits
Maryland 28a-f shuw 1 at once.	ţo	1.7	gany		Cumk	perland									1 Yes 2 No
Mary r 28a ed at	Director	10e. Street and Number					10f. Zip	Code				10g. Cit	izen of Wha	at Coun	try?
ı with the Maryland ms 23a or 28a-f sho be notified at once,		12606 Valley Vie					2	1502					USA		
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2	Married	Was Deceder Armed Forces					panic Origi , Mexican,		cify Yes or N	0-	14. Race - White,		can Indian, Black,
r dea or it	Fur			1 Yes	2 No						,,		Specify:		2
s afte rral",	by	3 Widowed 4 15. Decedent's Education (f Yas, Give Year or Dates:		1		7	specify:			Lini			
hour frant	Completed	Elementary/Secondary (0		College (1-4 or		16a. Deceden during m			DO NOT u			16b. I	Kind of Bus	iness/ir	ndustry
36 nin 72 E. than dical	ple	12	12)	College (1-4 of	3+)	F	tanene	eker				10	wn Home	≘	
15-00 filed with Hygien d other	тo	17. Father's Name (First, Mic	lole, Last)						18 Mother's	s Name (First, Middlo,				
215 e file lal Hy ked n	Be (John Newhouse	, ,								ls) Shel		, our ricinio,		
21215-0036 suld be filel within ? Mental Hygiene. marked uther than	ToE	19a. Informant's Name/Relat	onship (Typ	oe, Print)		19b. Mailing	Address	S (Stree	t and Numb	ber or Ru	ral Route Nu	mber, C	ity or Town	. State.	Zip Code)
MD d 2 sho lith and n 27 is		Hilda Shell/Mot	her								erland M				
ore, MD 2 ges 1 and 2 shou of Health and N If item 27 is n ther traumatic		20a. Method of Disposition				Place of Dispos			netery,		Date	20c.	Location -	City or	Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury ur other traumatic event, the Medical Examiner		1 Burial 2 Crem		Removal from S	tate	crematory or other				44 /	1 1 100	K	eyser l	W	
Baltimo permit. Page Department o Important: injury or oth		4 Donation 5 Other 21. Signature of Funeral Ser		ee	<u> </u>	bin Run (of Facility	11/	14/12				
in in Depression Barrellin in		(15)	2			Sca	npel	li Fu	of Facility	Hame 1	P.A.	2150	12		
Physician		23a. Part I. Enter the disease	, or complic	ations that cause	d the death.	Do not enter the	ne mode	of dying,	such as ca	ardiac or i	Land MD respiratory ar	rest, sho	ock, or hea	rt	Approximate Interval
/Medical		failure. List only one ca			twoin	tootin	.1 ц.	0 m 0 m	uh a a a						Between Onset and Death
xaminer		Immediate Cause (Final dise or condition resulting in deat	h) Du	Jpper Gas ue to (or as a cons	sequence of	ncescina n:	ar ne	anior	rnage						
		Sequentially list conditions,		Gastric U											
	Examiner	if any, leading to immediate cause. Enter Underlying Ca		ue to (or as a cons	sequence of	f):									
	ami	(Disease or injury that initiat events resulting in death) La	ed ^{C.} —	ue to (or as a cons	sequence of	f)·									
uted d ansit		events resulting in death) La	d.	20 (0) 40 4 00 1	004001100 01	75									
exect an an al - tr	<u>s</u>	▼ UNPENDED		AMENDED 23a	a-b,pt	.II,27	per	me,	g933	11-2	8-12 s	m			
3760, ficate be executed g physician and s the burial - transit	/Medical	IF FEMALE:		23c. If yes, outco	me of pregr	nancy						23	d. Date of c	leliven	
587 rtifica ling p	au/	23b. Was decedent pregnant past 12 months?	in the	1 Live birth		2 Fe	al death	3 [Ectopic	pregnan	су		Month		ay Year
Box 68' he death certifi the attending	Sici		Unknown		t time of de	ath 5 Ot	ner (Spe	cify)							
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ires that the signed by I be detache	ğ	Part II. Other significant co			th but not re	esulting in the u	nderlying	g cause g	jiven in Par	rt I.		_		_	he cause of death?
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Cords law requi has been 2 should	E E										24a, Was auto	psy			opsy findings available ompletion of cause of
Division of Vital Records, talen Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be a been side of the funeral director, page 2 should be a second to be a second t	Completed										perfo 1 ✓ Yes	ormed? 2 N		eath?	2 No
Vital Rec ysician: The l his certificate l	BeC	25. Was case referred to me	lical					26.Place	of Death (Check or					
Vita nysici direc	၀၂	examiner? 1 ✓ Yes 2 No	Hos	spital: 1 Inpati	ent 2	ER/Outpatient	3 🗌 D	OA	Other4	Nursing	Home 5	Reside	ence 6 🗸	Other:	Scene
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pital Diffilled	Certification:		etermined	(Specify)							or Town,	State)			
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Division of Vital Records, P.O. Box 68760, To the Hospital nr Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	edical		a	on the basis of exa and manner stated	amination er	nd/or investigat	ion, in my	y opinion	, death occ	curred at t	the time, date	and pla	ace, and du	e to the	cause(s)
	Σ	29b. Signature and title of ce	tifier	<i>f</i> .			290		e number			29d.	Date signe	d (Mon	th, Day, Year)
		lard	C H	tella	N			O.C.	M.E.			Nov	ember 1	1, 20	12
-		30. Name and address of pe			•	,						•			
		Carol H. Allan, MD		ant Medical E				re Stre	et, Baltir	more, I	VID 21223				
St Regist		31. Date filed (Month, Day Ye	2012	32. Registra	ars Signatu	park									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Howard Stanley Davis III October 29ay 2012ª 10:29 AMM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 408 Schley Avenue Frederick Frederick 8. Date of Birth (Month, Day, Year) Oct. 22, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days Hours Min. 219-46-3038 Country) Maryland Director 1 Å M 2 □ F 67 1945 Yrs Usual Residence of Decedent 28a-f shor 10b. County 10c. City, Town or Location the Maryland Director 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified. Maryland Frederick Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a 408 Schley Avenue 21702 U.S.A. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 1968-1972 Year or Dates! þ 1 Never Married 2 X Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Locomotive Engineer Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Maryellen Fogler Howard Stanley Davis, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Frances E. Davis, wife 408 Schley Ave., Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory Oct. 31, 2012 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD 21. Signature of Funeral Service Licensee Keeney and Basford PA Funeral Home M00255 106 East Church St. Frederick. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition MULTIFORME Physicianz GLIOBLASTOMA MONTHS Medical resulting in death) Due to (or as a consequence of) YEARS Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and if for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the a 5 Other (specify) Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No been si should 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physiciam: within 24 hours after death.

To the Funeral Director: After this certifici completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 X No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28c. Injury at 1 Natural 5 Pending injury Work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide
Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: Ty the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

BX

State

SADAF TALMUR

32. Registrar's Signature

RESAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Taimur,

3

31. Date filed (Month, Day, Year)

6/9/0

MD 46-b Thomas Johnson Drive, Suite 200, Frederick, MD 21702

10-31-2012

State

Registrar

31. Date filed (Month, Day, Year)

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arka

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G934 12/26/2012 Jh State of Maryland / Department of Health and Mental Hygiene 2 | | 2 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 10HODM Caroline Smith Dudley 2012 Medical acility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Sauce 2 ate of Birth 7. Age (In yrs. If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 219-05 last birthday) **Funeral** (Month, Day, Year) Months Hours Min Director 1 M 2 X F Yrs. 95 11/30/1916 Maryland Usual Residence of Decedent it of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1109 S. Schumaker Drive 21804 USA Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify If Yes, Give White 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) anoline Widley Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it. Page 1 and 2 should be file interest of Health and Mental Intent: If item 27 is marked of 2 John William Smith Annette Whitmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Dudley-Eshbach/Daughter 1116 Camden Ave., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State permit. Page Dep rtment Imp rtant: I any njury o ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 10/31/2012 Salisbury, MD Signature of F, neral S, rvice Licensee 22. Name and Address of Facility
Holloway Funeral Home Professional Association CFSP Dompson 501 Snow Hill Rd Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: bunial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. P.O. Box 68760 as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for L Month Day Year Pregnant at time of death 1 ☐ Yes 2 № 9 ☐ Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe Division of Vital Records, 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy perform 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA SPICE ပ 6 Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No Natural injury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔟 🗲 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Datę signed (Month, Day, Year) HB25 completed cause of death (Item 23a) (Type, Print) EASTERN SHONE

State

32. Registrar's

Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Calvin Dennis Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Min. Hours (Month, Day, Year) Director 214-28-3608 1 XM 2 □ F 88 10-10-1924 MD 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Exeminer must be notified at 10d. Inside City Limits Director 28a-f Baltimore City Baltimore 1 X Yes 2 No 10e. Street and Number 6 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 1508 Upshire Road 21218 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No
1f Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 仑 1 Never Married 2 Married Il Hygiene. 1 ☐ Yes 2 X No Specify: SpecBlack Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Svsco Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ဂ္ Depertment of Health and Ments Important: If item 27 is marked any Injury or call <u>Orvin Dennis</u> Viola Schoolfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harriett Dennis/Wife Upshire Rd, Baltimore, MD 21218 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place⊕ M 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St.James Holiness 11-3-2012 Snow Hill, MD Signature of Funeral Service Licenses 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury, MD 21801 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ thmia disease or condition Arrhy Medical resulting in death) Due to (or as a consequence of) Examiner Coronary artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami or Attending Physician: The lew requires that the death certificate be executed ettending physicien end I for use as the burlal-transit Hupertension Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year signed by the e 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been sign 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 this certificate 2 4 No 1 Yes director. 8 Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PNo ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA funeral To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D0062689 October 25 2012 HB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) fer MD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen October 27 Egana 2012 2:16 PM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 6351 Spring Ridge Parkway Apt 330 Frederick 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 109-32-6477 Director 1 □ M 2 🗓 F 83 New York June 4, 1929 ul Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 □ No Frederick Maryland Frederick 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 United States 6351 Spring Ridge Parkway Apt 330 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be permit. Page 1 and 2 should be filed. Department of Health and Mental Primortant: If item 27 is many injury or other sones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ Guillermina Ortega Eliseo Crespo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Pliszak/Daughter 4525 Roop Road, Mount Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Saint Anthony's Cemetery 11/8/2012 Nanuet, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home MO1646 106 E. Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 30 pable Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burlad-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 12 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 3 146 [은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Watural iniury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10-29-1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

MOV 20

12-08099	. F	Please Type or Print in Black Indelible Ink. Ensure All Copi		ible.	271.1
Mikaylia Chyenn		State of Maryland / Department of Health and Mental For State Certificate of Death		2012	3741
Physicis		Registrar 1. Decedent's Name (First, Middle,Last)	Reg	j. No.	3. Time of Death
Physicia Medical Exami		MIKAYLA CHEYENNE FOX	Month October 25	Day Year , 20 12	2320 hrs
•		4a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center 4b. City, Town, or Location of Deat Salisbury	.h	4c. County of Death Wicomico	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr Months Days Hours Mir	n	(MM/DD/YYYY) 9. Birt Foreig	
		225950568 1 M 2 F / O Yrs. Will bays Hours Will Usual Residence of Decedent	SEPTEMB	ER 17 2002 Co.	intry) VIRGINIA
i low any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 Yes 2 No
th the Maryland 23s or 28s-f show	ecto	VIRGINIA ACCOMACK SANFORD 10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	try?
ith the ? 23s or 10tifie	Funeral Director	23533 SNX/S ROND 23426 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S		JSA 14. Race - Americ	ean Indian Black
death w	une	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White, etc.	art indiani, black,
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	ē	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	work done	Specify: WH/ 16b. Kind of Business/li	
ID 21215-0036 ; should be filed within 72 hours afte and Mental Hygiene. 77 is marked other than "natural", matte event, the Medical Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	tired)		
withii yiene.	E	5 7 7 17. Father's Name (First, Middle, Last) STUDENT 18. Mother's Name	e (First, Middle, Ma	siden Curnema)	
of 15					
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica		JAMES W. FOX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Route Numb	er, City or Town, State,	Zip Code)
MD and 2 sho salth and em 27 is reumati		JAMES W- FOX FATHER 23533 SAXIS ROAD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	SANFOR	D VIRGINI	9 23426
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other tranmatic event, the Medical Examiner.		1 Surial 2 Cremation 3 Removal from State crematory or other place)			
altin mit. P. spartmes nportan jury or	ł	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee DOLWINGS CEMETERY OCT. 22. Name and Address of Facility = Cx	FUNERAL	HOME P.C	BOX 278
ம் உத்தத் Physician	4	7). Doll TEMPERANCEVILLE 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	VIRG.	INIA 2344	Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot Wound of Chest			Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):			
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
ted 1 insit	cal Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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Box 68760, re death certificate be the attending physicing for use as the burned for use		FFEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 2 Fetal death 3 Ectopic pregnancy 2 Fetal death 3 Ectopic pregnancy 3 Fetal death 3 Ectopic pregnancy 3 Fetal death 3 Fetal	ancy	23d. Date of delivery Month D	ay Year
Sox 6 death ce e attend I for use	ysicia	1			
Records, P.O. In The law requires that the law requires that the locate has been signed by the page 2 should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to t	
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the start cleath. *I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.			24a. Was ar	24b. Were aut	opsy findings available
Recol	Completed		autopsy perform 1 ✓ Yes 2	ed? death?	mpletion of cause of
certific ector, 1	Be	25. Was case referred to medical examiner? 26. Place of Death (Check examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other4 Nursing Nurs			
of Vi g Physi fer this	의	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c, Injury at Work?	28d. Describe ho	esidence 6 Other:	
Sion (Attendin death. Ector: A the fun	ation	1 Natural 5 Pending Oct 25, 2012 2208 hrs 1 Yes 2 ✓ No	Subject shot		
Divisital or A strength of the control of the contr	Certification:	3 Suicide 6 Could not be determined Could not be determined (Specify) Single Family Home	or Town, Sta	eet and Number or Rur te) ad, Sanford, VA	al Route Number, City
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
F 2 5 8	Me	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mon	th, Day, Year)
110-	-	30. Name and address of person who completed cause of death (Item 23a)			
IHB		Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	, MD 21223		
Sta Regist	ate rar	31. Date filed (Month, Pay Year) 32. Registrar's Signature			

Maryland 21215-0036 Baltimore, that the death certificate be Box 68760 Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Waven Ger Physician/ Year 08:50 AM 2012 Viola Frances Golden Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6114 Hess Road Hancock Washington Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Days 04^M09/1925 Director Yrs. 215-20-8392 87 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at aurantic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🏌 No Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6114 Hess Road 21750 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 X No 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 1 and 2 should be of Health and Ments fitem 27 is marked rother traumatic e John Wilbur Fulmer Mary Magdaline Shank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 Pious Ridge RD Berkeley Springs, WV 25411 Patricia A.Riggleman/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt.Olivet Presbyterian11/13/2012 Hancock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street M00260 Grove FUneral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Opeet and Death Physician/ a Chtonic disease or condition distrutive Dulmonary YEAR Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending | within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature at License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northern 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 28, 2012 Mabel Ruth Griffith 9:24 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3991 Friendsville-Addison Rd. Friendsville Garrett 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days 218-16-4514 Hours Director 1 🗆 M 2 🔼 F April 30, 1922 90 Maryland Usual Residence of Deceder or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 K No MD Garrett Friendsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3991 Friendsville-Addison Rd. 21531 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black White etc. ģ 1 Never Married 2 Married ☐ Yes 2 🕅 No 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify. 3 X Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 I h and Mental Hygiene. 7 Is marked other than "r (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clark Frazee Daisy VanSickle 1 and 2 should to the Health and Meitem 27 Is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon K. Buckel/Daughter P.O. Box l, Bittinger, MD 21522 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 5 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Injury o Addison Cemetery Nov. 2, 2012 Addison, PA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. any Z P.O. Box 275, Grantsville, MD 23a. Part 1. Entectoe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Congestive Heart Failure Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physiclan and for use as the burial-transit or Attending Physician: The law requires that the deeth certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death 2 🔀 No is certificate has been signed by the director, page 2 should be detached g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 x No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performed' 2 🗌 No 1 Yes Yes 2 V No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 😾 Residence 6 Nother (Specify) Hospital: 1 ☐ Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Lacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

69 Wolf Acres Rd., Oakland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DO,

32. Registrar's Signature

Daniel Miller,

-8 2012

31. Date filed (Month, Day, Year)

H-26154

October 29, 2012

21550

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>012</u> Year **Physician** 1, Woodrow Gordon Nov. 4:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dennett Road Manor Garrett Oakland Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 1 X M 2 □ F Director 233-34-5408 89 3/30/1923 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Modical Examinar must be rodified at 1 ☐Yes 2 ▼No **Funeral Director** MD Garrett Oakland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 195 Fairview Church Road U.S.A. 21550 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Carpenter Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: If item 27 is marked or any Injury or other traumatic eve William Gordon Dora Thomas LouCynthia Rinker ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Gordon/ Wife 195 Fairview Church RD., Oakland, MD 21550 20b. Place of Disposition (Name of Fertiley Generally or other place)
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11/6/12 Oakland, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 203 S. Second St., Oakland, MD 23a. Part1. Enter the disease, or complicing a last clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Presmaria wk disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gauss (Unsease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Division of Vital Records, Alzheiner's denentia 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an funeral director, page 2 autopsy performe 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🌠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) 29c. License number 11/1/2012 Patricia B Motes M D4507-1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

VA or

Patricia Gotsch MD

NOV - 7 2012

31. Date filed (Month, Day, Year)

Box 68760.

P.O.

park

4th St. Suite 1, Oakland, MD 21550

255 N.

32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Edward Gilbert 20°12 7:24 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Director 192-16-3418 88 1 🔀 M 2 🗆 F Dec. 31, 1923 Pennsylvania ; filed within 72 noustal Hygiene.
ed other than "natural", or items 23a or 28a-f show
ed other than "natural", or items 23a or 28a-f show
event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Frederick Frederick 1 XX Yes 2 ☐ No 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? Funeral 605 Humberson Lane 21703 United States 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 X Married ğ Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) United States College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Mechanical Engineer Department of Energy e 1 and 2 should be filed wir of Health and Mental Hygie If Item 27 is marked other or other traumatic event, <u>the</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carl Gilbert Bertha Goldner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health an Important: If Item 27 is any injury or other tra 914 Motter Place, Frederick, MD 21701 Sally Sorbello / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct. 1 Burial 2 Cremation 3 Removal from State Resthaven Crematory 2012 4 ☐ Donation 5 ☐ Other (Spec(V)) Frederick, Maryland 21. Signature of Funeral Service Prensee ²² Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Rart 1. Enter the disease, or co plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List o Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): and I-transit Exami Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use es the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) Year signed by the a 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an To the Hospital or Attending raysician, the within 24 hours after death.

To the Funeral Director. After this certificate has t completely filled in by the funeral director, page 2 s 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No ၉ 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1💢 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation ☐ Accider
☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certified 29c. License numbe 29d. Date signed (Month, Day, Year) 29 1)0069065 101

Registrar

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31. Date filed (Month, Day, Year)

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Anugeet

400 West 7th Street, Frederick, MD 21701

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #16b Maryland /FCHD TM ent of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Richard Grove, Jr. $0c_{tober}^{Month}$ 25, 201_{2}^{Nonth} 10:50 p. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1434 Souder Road Frederick Knoxville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours (Month, Day, Year Director 219-54-2466 1 □XM 2 □ F 62 Dec 26. 1949 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Knoxville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1434 Souder Road 21758 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: white Specify 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Excavating Elementary/Secondary (0-12) College (1-4 or 5+) President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ္ရ Richard N. Grove, Sr. Betty Remsberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melody Grove - wife 1434 Souder Road, Knoxville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State Park Heights 11-1-2012 Brunswick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ pan Creat month Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Certificate: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of): attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day eral Director: After this certificate has been signed by the ifilled in by the funeral director, page 2 should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed' 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manney of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours at To the Funeral D completely filled it Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) px 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) athleen 31. Date filed (Month, Day, Year) 32. Registrar's Signature State galden. Registrar

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2012 Donna Rae Gartland 27, 7:00 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7365 Prospect Hill Rd. Charles LaPlata If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Dav. Year Months 578-62-3392 Director 1 M 2 X F June 24, 1943 69 Usual Residence of Decedent Wash. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Charles 1 Yes 2xxNo LaPlata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7365 Prospect Hill Rd. 20646 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. hours after þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Hygiene. other than "natural", 1 ☐ Yes 2 ▼ No Specify: Specify: White 3 Widowed 4XXDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic excellent. Hairdresser Beauty Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Brown Irene Duvall 19a. Informant's Name/Relationship (Type, Print)
Kimberly G. Keller/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7365 Prospect Hill Rd. LaPlata, Md. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Brinsfield-Echols Crem. 10/31/2012 Charlotte Hall, Md. 4 Donation 5 Other (Specify) Signature of Juneral Service License 22. Name and Address of Facility Arehart-Echols Funeral Home, PA an MOO945 P.O. Box 567 LaPlata, Md. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cPhysician/ Huntington's Chorea disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Dementia Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) fo in the past 12 months?

1 Yes 2XXNo Day Month Year Pregnant at time of death Unknown 9 Unknown þ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' 1 Yes 2 No Yes 2 xxx 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2XX_{No} Hospital Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Xxesidence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 X Natural nours after death.

neral Director: Af

filled in by the fu

within 24 hours To the Funeral

completely

Medical

Registrar DHMH 17 Rev 06-2011 Accident

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Suicide

4 Homicide

29a, Certifier

Investigation

determined

under

Ali Rahimian MD 10403 Hospital Dr. G06 Clinton, MD 20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D0052999

28f. Location (Street and Number or Rural Route Number, City or Town, State)

10/30/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19^{Day} Physician/ Menth 20 12° 7:41 AM Theodore Green Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) 447-34-7496 74 **Director** 1 **X** M 2 □ F 10/9/38 er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4815 Newman Road 20748 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian, Armed Forces?

1 4 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 959-1979 Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Personnel Specialist Federal Government years Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hi Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Sumame) Richard Green Nona Braggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4815 Newman Road Temple Hills, MD 20748 Patricia A. Green/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11/08/2012 Cheltenham, MD 4 Donation 5 Other (Specify) Veterans Cemetery Signature of Funeral Service Vicensee 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Huper Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed physician and sthe burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the aid be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 1 Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical examiner? Be Division of Vital 26. Place of Death (Check only one) Other: 1 Yes ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 R/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work: 1 Yes 2 No ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D68695 JA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lara Oyedele, 7503 MD Surratts Road Clinton, MD 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Parter HOY W 2 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month GARNER GERTRUDE 12:00P M $\cap CT$ 26 2012 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CHARLES BRYANS ROAD ROAD 2979 THOMAS If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday **Funeral** 579-34-2526 **Director** 1 M 2 X F 82 Yrs MAR. 12, 1930 WASH., DC Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at Director BRYANS ROAD 1 Yes 2X No CHARLES MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral S. or items 23a 20616 2979 THOMAS ROAD 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Yes. Give 1 ☐ Yes XX No Specify: "natural", Completed 3 ₩ Widowed 4 Divorced Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working than , life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) DOCTOR'S OFFICE RECEPTIONIST 1 and 2 should be filed with House of Health and Mental Hygie item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, DELA GERTRUDE CLARK GEORGE EDWARD GARNER JR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2258 SANDALWOOD DR., WALDORF, MD 20601 JANICE ZANGWILL/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State NOVEMBER Department of I . Page 1 1 Burial 2X Cremation 3 Removal from State 2, 2012 ALEXANDRIA, 4 Donation 5 Other (Specify) METRO. CREMATORY Signature of Funeral Service License 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 an M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ CN 20N1 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death Month Day Year P.O. ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

1 Actural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Duvis

DHMH 17 Rev 06-2011

Registrar

iled (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For		State of	Marylan	d / Depa	artment of H	lealth a	and Me	ental Hy	giene		0	7100
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,	Medic Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death					of Death	10_	4c. County of Death		1227			
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936	s after al", or Exami	d by	1 X Never Married 3 ☐ Widowed 4 ☐		1 Yes 2 If Yes, Give Year or Dates		1	☐ Yes 2 🔀 No	Specify:				SpecifBlac		
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Baltimore,	permit. Pege 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: if item 27 is merked other than "netural", or items 23e or 28e-f show eny injury or other treumetic event, the Medical Examiner must be notified at once.		1 Burial 2X (Cremation 3 🗆 I				sition (Name of natory or other place		Dat	1		ocation - City or		ite
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9. 0.	that the	by PI	Part II. Other significan	nt conditions con	ntributing to deat	h but not resi	ulting in the u	ndertying cause giv	en in Part I.		23e. Did to	obacco i	use contribute to	the cause	e of death?
ds,	equires en sig rould b	ted	Max	phil i	Bull	eg		<u>-</u>			1 🗆 '	Yes 2	No 3□P	robably	4 Unknown
O O	has be	mple									24a. Was autop	sy	24b. Were au prior to death?		ings available n of cause of
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ō	ing Ph ffer th uneral		27. Manner of Death Natural 5	Pending	28a. Date of i		28b. Time of injury	28c. Injury	y at		d. Describe h				
sion	uttenul death ctor: A y the f	Certificate:	2 Accident 3 Suicide 6	Investigation Could not be	28e Place of	Injury - At ho	me farm etre	M 1 🗆	Yes 2 🗌 I		f Location (C	······································	of Mumber on Du	Davida	M
Division of Vital Records,	alor A after Direction		4 Homicide	determined		etc. (Specify)		ot, factory, office		20	City or Tow		d Number or Rui)	ai noute i	vumber,
_	To the Hospital or Attenuing Physicien: The lew requires that the death certificate be executed within 24 hour, after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely fille in by the funeral director, page 2 should be detached for use as the burial-trans.	Medical	29a. Certifier 1 🗡 (Check 2 🗌	Certifying Physi Medical Examin	cian: To the best er: On the basis of	of my knowled	edge, death of and/or invest	ccurred at the time	e, date and pon, death occ	place, and curred at the	due to the ca	ause(s) a	and manner as st	ated. cause(s) ar	nd manner stated.
	Vithin 2 To the I	Ž	only one) 3 1, 29b. Signature and stie	1	Practitioner: To	the best of m	ny knowledge,	death occurred at t 29c. License		e and place			e(s) and manner a te signed (Month		ar)
	. ,,,		Mu	m A	San	A	>	Ds	547	フラ		10	- 79-7	0/2	
			30. Name and address	of person who co	mpleted cause of	of death (Item	23a) (Type, P	rint)	/ / /		/ 1		man.		,
	Stat	e	31. Date filed (Month, D	Day, Year)	32. Regi	strar's Signat	ure /	-100 El	insill !	rt Zi	lishin	N/	MID CI	801	
	Registra		NOV 0	2 2012	Dener	B.	park					,			

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 08^{y} Mary Ellen Gormley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frostburg Allegany Frostburg Village Assisted Living Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 1 🗆 M 2 🗶 F 01-06-1922 Director 579-24-5274 90 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director Montgomery MD Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20905 U.S.A. 3453 Chiswick Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status þ 1 Never Married 2 Married 1 Yes 2 No within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) uth and Mental Hygiene. 27 is marked other than "n r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other important: ည Marv Elizabeth Nuggent Higgins James Nicholas Higgins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9700 Chisik Circle Eagle River AK 99577 Thomas Gormlev son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cumberland Crematory 11-09-2012 Cumberland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licenses Sowers Funeral Home. P.A. MO0547 Frostburg, MD 21532 Man Main St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ FAILURE CONCESTIVE Medical Examiner DRONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last the burial-Physician/Medical Box 68760 the attending plant IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 No 1 Yes 2 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an page 2 s autopsy performed? has Yes Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum_{\text{Nursing Home}}\) 1 Residence 6 \(\mathbb{O}\) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral is 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 08, 2012 026907

Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2012

3742

3, Time of Death

9. Birthplace (State or Foreign

Washington, DC

10d. Inside City Limits

1 Yes 2 No

10:30A M

2ŎT2

14. Race - American Indian, Black, White, etc.

White

Approximate Interval Between Onset and Death

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Month

Specify:

DHMH 17 Rev 7/2009

State

Registrar

Mar

925 Bishop Walsh

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margie Helen Giddings November 2, 2012 23:59 PM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Alfred House Eldercare Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan.10, 1932 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 577-42-2902 Hours **Director** 1 🗆 M 2 🖾 F 80 Usual Residence of Decedent 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince George's Beltsville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11209 Emack Road 20705 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc pernit. Paga 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiana. Important: If Itam 27 is marked other than "natural", or any injury or other traumatic avent, the Medical Eventions. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: 3 X Widowed 4 ☐ Divorced If Yes, Give White Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Banker Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Columbia Elizabeth Barnes Erby Goad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. James W. Giddings, Jr. -son 24705 Farmview Lane Damascus, Maryland 20872 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St. Johns Fpisc. (h. Cemetery 11/8/2012 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bonald V: Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Monald 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Instant Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of): ^eExaminer Sequentially list conditions, if any, leading to immediate cause. Enter underlying Due to (or as a consequence of) Exami physician and s tha burlai-transit Cause (Disease or injury that initiated events The law raquiras that the daath cartificata be axecutad Due to (or as a consequence of): resulting in death) Last Physician/Medical attanding p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month ate has baen signed by tha a paga 2 should ba datachad t 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia; Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
☐ Yes 2 ☐ No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? diractor Be 26. Place of Death (Check only one) Hospital: 2 X No Other: |2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4□Nursing Home 5□Residence 6♥Other (SASSISTED LVng within 24 hours aftar death.

To the Funaral Director: Aftar this completaly fillad in by tha funaral o 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one and title of certifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D28656 November 5, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passí, M.D. 15245 Shady Grove Road, #130 Rockville, Maryland 20850 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

NOV 1 9 2012

Box 68760

P.0.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Goldsmitt 10,20 Day 25 OCTOBER 2012 1:50A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHARLES CO. NURSING & REHAB.CNT PLATA CHARLES 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Days Hours Min JAN. 27 Pearl 937 MARYLAND **Director** 75 217-34-0124 Usual Residence of Decedent 28a-f show the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🎦 No MD CHARLES HUGHESVILLE ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe Funeral 23a 7335 OLIVERS SHOP ROAD 20637 U. S. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? i "natural", or i edical Examin by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes KNo Specify: Completed 3 Widowed 4 Divorced Specify: WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) OMEMAKER HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever THOMAS IRVIN JAMESON MARION REBECCA RUTHERFORD 19a. Informant's Name/Relationship (Type, Print)HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a ROBERT S. GOLDSMITH SR. 7335 OLIVERS SHOP RD., HUGHESVILLE, MD20637 Department of Healt Important: If item 2 any Injury or other once. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 OCTOBER 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 29,2012 CREMATORY ALEXANDRIA 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. Signature of Funeral Service. 5635 WASHINGTON AVE., LA PLATA, MD M00641 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) B Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day signed by the at d be detached for Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Seizuse discretur, Coronale Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, vision of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 10 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred M Natural 5 Pending work? 1 Yes 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blvd, Ste B, Glen Busnie, mD, 2106/

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11707/2012 Betsy Ann Harner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 531 Hall Court Harford Havre de Grace Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 0670371960 Maryland 206-54-4765 52 Director 1 □ M 2 🗓 F Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f st e notified |MD|Harford Havre de Grace 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? be "natural", or items 23a Funeral 531 Hall Court 21078 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 1 Never Married 2 X Married þ 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Office Coordinator Office Management item 27 is marked other other traumatic event, # Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Albert Haywood Barbara Snook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Harner (husband) 531 Hall Ct. Havre de Grace, Maryland 21078 20a. Method of Disposition 20c. Location - City or Town, State West Chester, 20b. Place of Disposition (Name of Date Department of H Important: If ite any injury or oth once. cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) RA Ferris & Co 11/09/12 Pennsylvania 22. Name and Address of Facility Zellman Funeral Home, P.A. S. Washington St. Havre de Grace MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disea Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 no 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural injury work? Accident 2 No Investigation filled in by the t 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) D0065827 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 27 Bernard Maurice Hargett 6:34 p M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country Mary land **Funeral** 7. Age (In vrs. last birthday) January 9, 1948 219-46-0909 1 X M 2 □ F 64 Director 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items 23a or 28e-f show other traumatic event, th. Medical Estimater in unatter routility of at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗓 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6001 Quinn Road 21701 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 77. 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ۵ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Year or Dates. Vietnam Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) County Government Maintenance Worker 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Bernard Maurice Hargett, Sr. Madeline Sier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6732 Remsburg Road, Sharpsburg, MD 21782 Kimberly Scott / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Noveliber 2 permit. Page 1 Department of Important: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery 2012 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signatus Funeral Service Licensee Keeney dands Basford PA Funeral Home, 106 East Church St., Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ettending physician and I for use as the burial-transit Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed annual that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death ed by the e Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ. HELONINIS Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has I in by the funeral director, page 2.5 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2**X** No Other: |2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours aft To the Funeral Dil completely filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 10/27/2012 ss of person who completed cause of death (Item 23a) (Type, Print) MCK Memorial Homes 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Harrington Marianne 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death REGIONAL HICOMICO If Under 1 Year | If Under 24 Hrs Security Number Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Director 219-32-5091 1 M 2 CKF 77 8-25-1935 Avon, Ohio 28a-f shov 10a. State 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Ocean Pines 1 Nes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 11 Cresthaven Road 21811 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 🔀 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐kNo Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Interior Decorator Self Employed æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen V. Keller Paul G. Lane and 2 should be Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21811 6212 South Point Rd. Berlin, Md. Mary H. Bane-Daughter Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Importent: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11-2-2012 Berlin, MD. Evergreen Cem. 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Servi 108 William Street, Berlin, MD. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease of injury Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Pregnant at time of death ed by the a 9 Unknown P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autons this certificate Performed?

☐ Yes 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No. eral Director: A filled in by the fu Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DH 6

Registrar

DHMH 17 Rev 06-2011

State

100 E

CATTOIL

BAIDAIS

M.O.

Registrar's Signature

SALISBUM,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 27, 2012 Hilliard Jr Julius 10:52 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) Director 1 M 2 □ F 226-50-0573 69 07-01-1943 Newport News, VA Usual Residence of Decedent or than "natural", or Items 23a or 28a-f show the Medicel Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Camp Springs MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6904 Coolridge Rd 20748 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. <u>۾</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates,1968 1 ☐ Yes 2 K No Specify. Specify: Black Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Fire Investigator D.C. Government Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental H ည Julius Hilliard Mary Pittman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health at Important: If item 27 Is any Injury or other trees. Patricia Hilliard/ Wife 6904 Coolridge Rd Camp Spring MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Veterans Cemetery 11/13/2012 Cheltenham, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd Brentwood MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death ule Arterosclerotic Cordiovas _Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner JADELLIDIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated account of the control of the con Examine Due to (or as a consequence of): hypertension The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical mellit Box 68760 yes, outcome of pregnancy

Live Birth 2 Petal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day signed by the at d be detached f 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be **Division of Vital** 26. Place of Death (Check only one) 2 No Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funera 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cent 29c. License number D0062057 4+1 54 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sandra Banks, MD 7503 Surratts Road

State Registrar

31. Date filed (Month, Day

32. Registrar's Signature

Clinton, MD 20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	ate of Marylan		artment of F tificate of D			giene Reg. No.2	12	37428		
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of Death		
police	Medic	al	Raymond C1: 4a. Facility Name (if not institution, give street		Holt,		Landing of Day	Nov.) 12	3:45 A M		
A. M	Examin	ier	10140 Dogwood Dri			4b. City, Town, or White E		tn	4c. County				
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days				9. Birthp	lace (State or Foreign		
lid	Director		577-40-2229	2 □ F 82	Yrs.			07/17/			ginia		
	land show d at	tor	10a. State 10b. County	10c. City	y, Town or Lo	cation				1	0d. Inside City Limits		
	Mary 28a-f notifie	Director	MD Charles	Wh	ite P	_					1 🗆 Yes 2 🔀 No		
	ith the 23a or st be r	ral	10e. Street and Number 10140 Dogwood Dri	We		10f. Zip Code 20695			10g. Citizen of United				
	within 72 hours after death with the Maryland jiene. 9r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	11. Marital Status 12. V	as Decedent Ever in U.S	S. 13. V	Vas Decedent of Hi	spanic Origin? (S	pecify Yes or No-		e - America			
36	after d I", or i	by	1 Never Married 2 X Married 1	rmed Forces?		f Yes, specify Cuba		to Rican, etc.)	Blac Specify	ck, White, e			
9	nours a	Completed	15. Decedent's Education	ear or Dates. 1932 on		lent's Usual Occupa	ation		16b. Kind of B	W II .	ite		
215	e. nan "r	dmc	(Specify only highest grade co. Elementary/Secondary (0-12) C	npleted) ollege (1-4 or 5+)	(Give I	kind of work done d O NOT use retired)	luring most of wo	rking			apping		
121		Be C	12 17. Father's Name (First, Middle, Last)		Nega	tive End	•		Agenc				
anc	e d ta	To E	Raymond C. Holt,	Sr.				me (First, Middle, 1 y J . E		9)			
ary	should be file and Mental I 7 Is marked c raumatic eve		19a. Informant's Name/Relationship (Type, Pr		19b. Mailin	g Address (Street a				State, Zip C	code)		
Σ,	1 and 2 should be of Health and Menitem 27 is marke other traumatic.		Maude F. Holt/Wife	e	1014	O Dogwoo	od Dr.	White	Plain	s, MI	20695		
Baltimore, Maryland 21215-0036	ige 1 and to the transfer of t		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Remo	val from State	emetery, cren	sition (Name of natory or other place	i	Date	20c. Location	-			
altin	permit. Page 1 a Department of H Important: If its any injury or of		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses	St		l's Ceme		14/12			MD c., P.A.		
ğ	permi Depar Impol any ir		Han But	MOOR MOOR							MD 20646		
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau	ns that caused the death							Approximate Interval Between		
إاحر	Phynician/ Medical	l V	Immediate Cause (Final disease or condition resulting in death)	Cance	2	9	lun	f .			Onset and Death		
-gad!	Examiner		Tooland in addition	Due to (or as a consequ	ience of):	90							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	Torico Jij.								
	and transi	xam	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ianaa afi:					_			
0	ss that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	edical Examiner	resulting in death) Last	Due to (or as a consequ	ierioe orj.								
	ficate g phys		d										
× 68	th cert tendin or use	ian/I	in the past 12 months?	yes, outcome of pregna	l death 3	Ectopic pregnanc	y			te of delive			
Box	the at	Physician/M	1 Ves 2 No 4	☐ Pregnant at time of d☐ Unknown	leath 5 L	Other (specify)			Mic	Month Day Year			
P.O.	that th	by Ph	Part II. Other significant conditions contribu	ting to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use cont	ribute to th	e cause of death?		
ds,	requires been sigi should bo							1 🗆 🗅	Yes 2 □ No	3 🗆 Prob	ably Unknown		
cor	law rei nas be e 2 sho	Completed						24a. Was a	sy	prior to cor	sy findings available mpletion of cause of		
Re	i: The icate h		05 Manager of the analysis					1 \(\text{Yes}		death? 1 Yes	2 🗆 No		
/ita	/siciar s certii directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospit	al: 1 Inpatient 2	ER/Outnatien	_ Othe	r:	Home 5 Resid	lanca 6 🗆 Oth	or (Coosifu)			
of	ng Phy ter this		27. Manner of Death 1 Natural 5 □ Pending	ia. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at	1	ow injury occurr				
ion	tendir death. tor; Af the fu	Certificate:	2 Accident Investigation			M 1 🗆 '	Yes 2 No	ļ					
Division of Vital Records,	l or At after (Direc)		4 Homicide determined	 e. Place of Injury - At ho building, etc. (Specify, 		et, factory, office		28f. Location (S City or Tow.	treet and Numb n, State)	er or Rural	Route Number,		
	ospita hours uneral	Medical	29a. Certifier 1 ertifying Physician:										
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Mec	(Check 2 Medical Examiner: Or only one) 3 Certifying Nurse Prac			death occurred at the	ne time, date and	place, and due to the	ne cause(s) and r	nanner as s	tated.		
	Nit Vij		29b. Signature and title of certifier			29c. License			29d. Date signed	d (Month, E	ay, Year)		
	11/1/20		30. Name and address of person who comple	ed cause of death (Item	23a) (Type, P	DJS wold			. 1				
	11. 140		TLOL DON	is Roa	d	wold	014	MD	706	03			
	Stat Registra		31. Date filed (Month, Day, Year) NOV 2 0 2012	32. Registrar's Signat	bare								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 17 E AMS HARRY 2012 3:15A Medical Nov 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Street Heritage 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Country Hours 4 10 1 1 9 2 6 220-22-8328 Director 86 1 □ M 2 🔀 F Yrs. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Street 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3964 Street Road 21154 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Speech Therapist Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Estelle Scarborough George Harry Davis 19a. Informant's Name/Relationship (Type, Print)
Donald D. Heaps/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 3589 Mill Green Road, Street, MD 21154 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: If it any injury or o cemetery, crematory or other place)
Highland Cem. 1 XBurial 2 Cremation 3 Removal from State 11/10/12 Street, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funderal Service Acens 22. Name and Address of Facility
Harkins Funeral Home, Inc., Delta, PA Kober 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed stop dementa Year that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical IF FFMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1)cubilis wicers 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No GERD 24a. Was an autopsy performed ASCUO Yes 2 N Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: assisted Livis Other: 4 Nursing Home 5 Residence 6 🕅 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Division after death. Director: Af Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, . City or Town, State) filled in by determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Klass D 3/295 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011 FlotsL

31. Date filed (Month, Day, Year)

Box 68760

Records,

of Vital

Kenwood

5701

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9-2012 8:26 PM Constance Victoria Hudson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbur pice Vicamic If Under 1 Year If Under 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 24 Hrs. Min. (Month, Day, Year) Director 1 □ M 2**X** F 214-46-4463 65 1-18-1947 MD show 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Director or 28a-f 1 Yes 2 XNo Ocean City MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 21842 USA 9830 Keyser Pt, Apt 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, 1 ☐ Yes 2 X No If Yes, Give Completed by 1 Never Married 2 Married permit, Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify:White 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Sahara Cafe 11 Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mable Parsons John Parsons injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21850 Department of Health a Important: If item 27 is any injury or other trau once. Philip Hudson/Son Apt 10, Pittsville, MD 7380 Gumboro Rd, 20b. Place of Disposition (Name of cemetery, crematory or other bidge) 20a. Method of Disposition 20c. Location - City or Town, State Date ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Cremation, 11-2-2012 Dover, DE 22. Name and Address of Facility Bennie Smith Funeral Home 21. Signature of Funeral Fervice Licenses 917 W. Isabella St. Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ACCIDENT ERBBROVAS CUCA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed physician and strans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending phate as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atte Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been signal director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autons 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No HOSPICE 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending n 24 hours after deam.
he Funeral Director: Aft Accident Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) 100 Wishing WAR 31. Date filed (Month, Day, 32. Registrar's State NOV 02 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month() Physician/ Annie D. Harris Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Peninsula Salisbury Regional Medical Center Wicomico If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Hours Min (Month, Day, Year) Director 215-36-1304 1 - M 2 X F 95 11-28-1916 Alabama Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at. 10a State 10b. Count 10c. City, Town or Location 10d Inside City Limits Director 1 Yes 2 X No MD Wicomico Eden 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 26210 Walnut Tree Road 21822 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Black White etc. 1 Never Married 2 Married Completed by within 72 hours after 1 ☐ Yes 2 X No Specify: and 2 should be filed within 72 hours aft Health and Mental Hygiene. tem 27 is marked other than "natural", SpecifyBlack 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Dulanev Foods Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ Lutina Sanders David Purifov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Callie Brown/Daughter 26210 Walnut Tree Rd, Eden, MD 21822 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If its
any injury or ot
once. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wesley Cem 11-3-2012 Manokin, MD Samuel 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury, MD 21801 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): igned by the attending physician and be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, I To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

30. Name

Maryland 21215-0036

Box 68760

Division of Vital

Card Street Salisbury MD 2180

ss of person who completed cause of death (Itom 23a) (Type, Print)

2012

32 Registrar's Signature

12-06592	Please Type or Print in Black indelible ink. Ensure All	Copies Are Legible.			
Ryan Spencer Hartnett	State of Maryland / Department of Health and Me	ental Hygiene	0010	0710)
1- For State Registrar	Certificate of Death	Reg. No.	2012	3743	ì
Physician/ 1. Decedent	s Name (First, Middle,Last)	2. Date of Death	3	B. Time of Death	_

-	1- For State Registrar	Certificate of	Death	Reg.	No. 2012	3/43
Physician Medical Examine	Ryan S		2. Date of Death Month Day November 12, 2012 3. Time of Death 1624 hrs			
,	4a. Facility Name (if not institution, give street and Telegraph Road East of Brick Mee		o. City, Town, or Location of Death Rising Sun		4c. County of Death Cecil	
Funeral Director	5. Social Security Number 6. Sex 215-37-4122 1 X M 2		nplace (State or Delaware			
Maryland 28a-f shuw any d at once,	Usual Residence of Decedent 10a. State 10b. County	F 20 Yrs. 10c. City, Town or Location Milford				10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a ur 28a-f shu untified at once	10e. Street and Number 4602 Summer Brook Way		10f. Zip Code 19963	10g.	Citizen of What County United St	
or items	3 Widowed 4 Divorced If Yes, Give	Decedent Ever in U.S. d Forces? If Yes 2 No Yeer 1 1	Decedent of Hispanic Origin? (Sis, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Americ White, etc. Specify: Whi	an Indian, Black,
nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", ather traumatic event, the Medical Examiner To Be Completed by		during most	s Usual Occupation (Give kind of vector of working life. DO NOT use reting the Mechanic	work done 16 red)	Sb. Kind of Business/In United S Air Forc	tates
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ore, MD 21215-003 so I and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other tt her traumatic event, the Med To Be Comm		19b. Mailing	Address (Street and Number or F	Rural Route Numbe		Zip Code)
imore Pages 1 ment of H hant: If in	20a. Method of Disposition 1 X Burial 2 Cremation 3 Remove 4 Donation 5 Other Specify:	Memorial C	eterans emetery 19,	ember 2012	Oc. Location - City or T	DE
Balt permit. Depart Import injury	21. Signature of Funeral Service Licensee Hustu Hull Cum	mu 1	me and Address of Facility Hic 03 W. Stockton	Street, E	Elkton, MD	1s, P.A. 21921
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Division of spital or Attending hours after death. acral Director: After filled in by the function:	3 Suicide 6 Could not be 28e. F	lace of Injury - At home, farm, street, ify) Local Street		or Town, State	et and Number or Rura e) East of Brick Meetir	
Divisior To the Haspital or Attend within 24 hours after death The Foureral Director: completely filled in by the Medical Certification	one) 2 Medical Examiner: On the base	best of my knowledge, death occurre sis of examination and/or investigatio er stated.	d at the time, date and place, and n, in my opinion, death occurred a	due to the cause(s)) and manner as stated I place, and due to the	i. cause(s)
	296. Signature end title of certifier Austrike One of the control of the contro		29c. License number O.C.M.E.		od. Date signed <i>(Mont</i> November 13, 20	
Util	30. Name and address of person who completed of Laron Locke MD. Assistant Med	cause of death (Item 23a) ical Examiner 900 W. Balt	imore Street, Baltimore, M	/ID 21223		
State Registra	31. Date filed (Month, Day, Year) 32.	Registrar's Signature				

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	-	For State Registrar	State of M	ai yiai i		tificate of		and iv	i c ittai i iy	Reg. No	001	2 3	71.33
Physicia	n/	1. Decedent's Name (First, Middle							2. Date of De			ır i	Time of Death
Medic	al	Rosa L. Jon						(5)	10/3	1/2	012		1:20 a ^M
Examin	er	3150 Heartle				4b. City, Town, o		of Death			County of D		
Funeral		5. Social Security Number	6. Sex 7. Ag		ast birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. Min.	8. Date of Bir	th	g.		(State or Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailin	g Address (Street					Town, State,	Zip Code)	
and 2 s Health tem 27 ther tra		Marian Spears	s/daughter			Heart	leaf	Ln.	Waldo	rf,	MD 2	0603	=-
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 Li Fetal death 3 Li Ectopic pregnancy							23d. Date of Month	delivery Day	Year	
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To th within To th comp	— r	29b. Signature and title of certifier	(c &).		,	29c. Licens		<u></u>			e signed (Mo		ear)
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Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fh g934 12-11-12 yt. State of Maryland? Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:05P M Marjorie Virginia Johnson 28 12 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery HCR Manor Care If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 107 1 □ M 2 🗓 F 9/18/1905 Maryland Director 578-16-3230 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 ☐ No DC None Washington Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number a or USA must 930 Farragut Street NW Apt.#416 20011 Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? traumatic event, the Medical Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Private Elementary/Secondary (0-12) College (1-4or 5+) Domestic 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jane Sarah Watson George Cooper ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11805 Carriage Horse Dr. Silver Spring, MD 20904 Department of Health a Important: If item 27 is any injury or other trainonce. Mary Helen Dove/Niece Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial 11/2/12 Suitland, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licensee 4308 Suitland Road Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final **Physician** Cardiopulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Atherosclerosis Sequentially list conditions, if an leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year for 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an page 2 performed? Yes 2 No certificate Physician: 25. Was case referred to medical funeral director, 26. Place of Death Check onl one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 Yes 2 No 1 Inpatient 2 ER/Outpatient ို this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Certification: 5 Pending investigation Injury Natural To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 2 Accident filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10-30- 2012 3.74 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

MUSGNOVE

25

32. Registrar's Signature

Immordino

Year)

RD.

Silver Spring MD 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1905 PM amar 2012 vovembe Medical Facility Name (if not institution, give 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10 8. Date of Birth (Month, Day, Year) Jan 30 1933 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Maryland 217-28-2706 79 Director 1 □ M 2 🔀 F Usual Residence of Decedent 28a-f show ms 23a or 28a-f shorms must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Kent Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6019 Jamar Rd. U.S.A. 21661 items death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: 3 X Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) 2 should be filed with the and Mental Hygien 7 is marked other the Homemaker Own Home 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl Zimmerman, Sr. Mary Hynson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 21876 Lovers Lane Rock Hall, MD. 21661 (daughter) Ina May Puppe Reed 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Wesley Chapel Cemetery 11/11/12 Rock Hall, MD. 4 Donation 5 Dother (Specify) 21. Signatur u eral Service Lic ... see 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech
118 West Cross St. Galena, MD. 21635 M00510 art 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart ailure. List only one cause on each line Immediate Cause Final Physician/ disease or condition resulting in death) Ca 7 lun

Due to (or as a donsequence of)y lung with year Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine otte to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown for Day the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? @ ASHO 24a. Was an page 2 autopsy this certificate has 1 Yes 2 No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 ☐ No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 1 Natural injury 5 Pending death. Investigation within 24 hours after death

To the Funeral Director: ,
completely filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

3 4

Registrar

DHMH 17 Rev 06-2011

> ///Lulum, MD

NOV 19

KIN K. WUN,
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signa

415 Washington Are, Chestertown, MD 21620

121313

11/8/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1 Month Rose Ann Kilby 2:58P M 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 579 48 1355 Days Hours Director 77 1 M 2 X F 11/21/1934 MD Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d, Inside City Limits items 23a or 28a-f sho ner must be notified at Director 1 XYes 2 No St. Mary's Mechanicsville 10e. Street and Number 10g. Citizen of What Country? Funeral 20659 USA 39431 Harpers Corner Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. "natural", or iterr edical Examiner r 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify. White Completed 3X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Private other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) id Mental ⊦ **marked** of Joseph Michael Burkhard Helen Marie Russell Health and N tem 27 is m€ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heath Tucker/ Grandson 5518 Notched Beak Ct.Waldorf,MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Department of F Important: If ite any injury or oth ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 10/31/12 Ft.Lincoln Cem. Brentwood, MD Signature of Funeral Service Lice 22. Name and Address of Facility Briscoe-Tonic Funeral Home 38576 Brett Way Mechanicsville, MD 20659 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final I-5 Chemic Ph si i n disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-tran attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery been signed by the atter should be detached for in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of Cance this certificate has autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 🗶 completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of Certificate: 1 Natural 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After (Month, Day, Year) injury 5 Pendina Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 0060472 d cause of death (Item 23a) (Type, Print)

Registrar

MD

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25500 Point Lookauthd Leonardtaun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Walter Kaufmann 2012 9:47 PM October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Charlotte Hall Veterans' Home Charlotte Hall St. Mary's 6. Sex 1 M 2 □ F Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year 1924 Dec. II 87 Maryland Director 578-22-6633 Usual Residence of Decedent 28a-f show 10a. State items 23a or 28a-f sho 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11535 Terrace Drive 20602 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Was Decedent Ever III 0.5.
Agned Forces?

1 Ves 2 Very
If Yes, Give Very
Year or Dates. 1941 – 1947 "natural", or iter Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2X No Specify: White Specify: 3 Midowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 8th. Security Guard |Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental h ည Walter Kaufmann Johannah Fowler Journal 2 sh.
Journal of Health and Important: If item 27 is many injury or other any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Robert Kaufmann/ Son 11535 Terrace Drive, Waldorf, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct. 24, 2012 Bryantown, MD Mary's Cemetery 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Huntt Funeral Home 3035 01d Washington Rd. Waldorf, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical consequence of Examine Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? γ THROMIC OBSTRUCTIVE PULMONARY 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed' Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 \sum Yes 2 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director. After th completed filled in by the funeral Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

My dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

of Vital

Division

DHMH 17 Rev 7/2009

29b. Sign

diet the time

Hall Bd. Charlotte Hall, MD-20622

Pertifying Nurse Practioners To the best of my knowledge

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	TOI.	Certificate of Death	, ,	Reg. No. 2012	37438	
	Physicia		Decedent's Name (First, Middle, Last) Mary Timney Kepner		2. Date of Dea	ember 09, 2012	3. Time of Death 0	
	Medic Examin		4a. Facility Name (if not institution, give street and number) 74 West Main Street	4b. City, Town, or Location of Death	coning	4c. County of Death	egany	
7	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	n 9. Birtho	lace (State or Foreign	
	Director		Usual Residence of Decedent		Decemo			
	// Aaryland 8a-f sho tified at	rector	10a. State 10b. County 10c. City, Town o Maryland Allegany	Lonaconing	5	10	0d. Inside City Limits 1 Yes 2 □ No	
	is 23a or 2 ust be no	Funeral Director	10e. Street and Number 74 West Main Street	10f. Zip Code 21539		10g. Citizen of What Count US		
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Never Married 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces?, 1 □ Yes 2 □ No If Yes, Give Year or Dates.	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify: 	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify:		
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yland	ld be filk Mental I arked c atic eve	70	Alexander Timney		Clara Warnick			
Mar	d 2 shou alth and 1 27 is m er traum		19a. Informant's Name/Relationship (Type, Print) 19b. N Gayle Fazenbaker - Great Niece	failing Address (Street and Number or Rura 17303 New Memory I				
Baltimore, Maryland 21215-0036	Page 1 and ment of Hermant: If item jury or othe		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	isposition (Name of crematory or other place) nberland Crematory	Présvember 12, 2012	20c. Location - City or Tox Cumberland		
Ball	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility 8 East Main St		orn-McKenzie Fun coning, MD 2153		
	ificate be executed Wedical Examiner as the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or inlinury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	LEROSIS	r respiratory arm	est,	Approximate Internal Between Priset and Death	
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Ital H	ysician: The law is certificate has be director, page 2 s	Be	25. Was case referred to medical examiner?	26. Place of Death (Check	1 \(\superset \text{Yes}\)	2 No 1 Yes	2 L No	
ō	ng Phy ter this neral d	ate: To	27. Mann of Death 28a. Date of injury (Month, Day, Year) Natural 5 Pending	atient 3 □ DOA	•	ence 6 Other (Specify) ow injury occurred		
Signature of the control of the cont								
	e Hospil 24 hour e Funera	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check only one) 3 Certifying Nyrse Practioner: To the best of my knowled	vestigation, in my opinion, death occurred at	the time, date ar	nd place, and due to the cau	se(s) and manner stated.	
	Nithii No th COTIA	~	29b. Signature and title of Septifier	29c. License number		29d. Date signed (Month, E		
	3 8		30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)	<u>/</u> /	IVOVERDE 1	1,000	
	Stat		31. Date filed (Month, Day) Year) 32. Registrar's Signature	bish Road, Stukey,	Cunho	lond, may	and Zisca	
	Registra	ir	NOV 2 0 2012 Burne D. Sax	Approx.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #3 Per PHY G934 12/10/2012 JH.

			For State		State of N	Marylan					ind M	lental Hy	giene				
			Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death										2-	37	439		
Н	Physicia			(* 11.00.0)	Gypsy B	onnio l	[ono					Month	Day 8	y Yea 20		3. Time of 5:5	4pm M
200	Medic T Examin		4a. Facility Name (if not institution, give			Lane	4b. City,	Town, or	Location of	f Death	11		County of D		7.50	<u>- F</u>
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	Funeral		5. Social Security I			ge (In yrs. Ia	st birthday)	If Unde Months		If Under 2 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da	th v. Year)	9.	Birthpla Country	ice (State c	or Foreign
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	or 28		10e. Street and Nu		neu			10f. Zip		Lymn	Heigh	its	10g. Cit	izen of What	Countr	y?	
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21215-0036	within 72 hours efter death with the Maryland glene. er then "neturel", or items 23a or 28e-f sho er the Medical Evaninar must be notified at	Completed	3 AL Widowed	15. Decedent's E	Year or Dates		16a. Deced	ent's Usu	al Occupa	tion			16b K	ind of Busine	Whi		
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Maryland			19a. Informant's N	lame/Relationship (7	ype, Print)		19b. Mailin	_				l Route Numbe			Zip Co	de)	
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Baltimore,	- 0		1 🔀 Bunial 2	P ☐ Cremation 3 ☐ To ☐ Other (Speci			emetery, cren			•			200. 20				
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876	tificat ng phi es th		IF FEMALE:														
Box 687	h cert tendii or use	lan/	23b. Was deceden	t pregnant	23c. If yes, outcom	h 2 🗌 Feta	Ideath 3			,				23d. Date of	-		
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0	ding Ph h. After th funeral		27. Manner of Dea Natural	th 5 Pending	28a. Date of in (Month, L	njury Day, Year)	28b. Time of injury		28c. I <i>n</i> jury work?	?	- 1	28d. Describe I	now injury	occurred			
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Division of Vital	i or Attend after death Director: A d in by the f	Cer	4 🗆 Homicide	determined		etc. (Specify		et, factor	y, onice			28f. Location (S City or Tov			Hurai H	oute Numi	oer,
	To the Hospital or Attending Physiclen: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physiclen end completely filled in by the funeral director, page 2 should be deteched for use as the burlel-trensi	Medical	29a. Certifier	1 Certifying Phy	sician: To the best	of my knowl	edge, death o	ccurred a	it the time	, date and	place, ar	nd due to the c	ause(s) a	nd manner a	s stated		
	he Ho in 24 he Fu ipletel	Med		2 Medical Exam 3 Certifying Nur	iner: On the basis o se Practitioner: To												anner stated.
_	Tot Tot		29b. Signature and	title of certifier	21/4	,		290	c. License	number	_			te signed (Me			
			11/4	repres	e fun	~/X	>		27	66.	20		- [1-7-	20	12	
		4	30. Name and add	lress of person who	completed cause of	death (item	23a) (Type, F	1	- 4	-1.	1	10	61.	1-9-	115	710	150
						0 4 0	1 3/ 1/										3 7//
	Sta	/ e	31. Date filed Mor	ith, Day, Year)	#2. Regis	trar's Signat	ure	7 90	urell	N:3	nua	y ou	NW	nec ;	1001	160	779

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 Day Physician/ : 02 AM LOCKS 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Waldort 6. Sex Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 5827 1 🗆 M 2 💢 F 8-11-1956 56 MARYLAND 28a-f show 10b. County 10c, City, Town or Location at 10d. Inside City Limits **Funeral Director** "natural", or items 23a or 28a-f sl edical Examiner must be notified Waldorf 1 Yes 2 No MARYLAND harles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Metro 3515 20601 USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 12. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Black Completed 3 Widowed 4 Divorced 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Toye 1040 19b. Mailing Address (Street and Number of 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trau NE 20011 Urel 126 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date rematory or other place, 1 N Burial 2 Cremation 3 Removal from State MD MARY'S 3-12 Bryantown 4 Donatio Other (Specify) Signatu Puneral Service Name and Address of Facility 2060 8 Part 1. Enter the disease, or complications that can chock, or heart failure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arre Approximate Interval Between Onset and Death Immediate Cause (Final Provincian/ ON disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death should be detached the P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed To Be Completed by or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 autopsy performed? 24 hours after death.

Funeral Director: After this certificate 2 🗌 No Yes 2 1 🗌 Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Deat 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1- Natural 1 🗌 Yes Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) C 30. Name and address of person who completed cause of death (Item 23a) (Type Dav Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:35P John Lewis Landreth 2012 October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Friends Nursing Home Sandy Spring Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Hours (Month, Day, Ye California Director 565-42-1858 95 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Brookeville 1 🗌 Yes 2 🕱 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral with United States 20833 21310 New Hampshire Avenue 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ■ Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give White WII Completed 3 🛮 Widowed 4 🗆 Divorced Year or Dates er than "natur , the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Radio Page 1 and 2 should be filed within iment of Health and Mental Hygiene. Fant: If item 27 is marked other thar lury or other traumatic event, the Meren or other traumatic event, the Meren or other traumatic event, the Meren or other traumatic event in the Meren or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) Rating Service Radio Rating Measurement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Alyne Doris King Thomas Chart Landreth, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Shear Landreth/Son 21310 New Hampshire Ave., Brookeville, MD 20833 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/28/12 Alexandria, Metropolitan Crem. 22. Name and Address of Facility Barber Funeral Home Laytonsville, Maryland 20882 0. Box 5038 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ RESPIRATOR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SPHAGIA Sequentially list condition, if any, leading to immediate cause. Enter Underlying Examiner or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last ALLIRE 10 and burial-tran Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ☐ Live Birth 2 ☐ Fetal deat Month Dav Year cate has been signed by the page 2 should be detached a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ, Division of Vital Records, 2 № No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 1 🗌 Yes 2 🗆 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 1 X Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 🗌 Yes 2 No + hours after death uneral Director: + the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a To the Hospital Medical 29a. Certifier 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deam occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

TK

State

30. Name and address of person who completed cause of death

31. Date filed (Month, Day, Year)

EMURY

LANDRE

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Item 23a) (Type, Print)

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ OCTOBER 24, Day 2012 JOHN LEWIS LEE 5:47 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CENTER CLINTON 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Director 577-18-8904 1 **X** M 2 □ F FEB. 6, 1922 VIRGINIA 90 Usual Residence of Deced item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10h Count 10a, State 10c. City, Town or Location 10d. Inside City Limits Direct BRYANS ROAD 1 X Yes 2 No MD CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
UNITED STATES Funeral 20616 6981 HEATHER DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. Yes 2 No 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Specify: BLACK Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) DRTVER FEDERAL GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည IDA MAE FOSTER LEE HAROLD LEE permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 LEE COURT, INDIAN HEAD, MARYLAND 20640 SHEILA COLE/CAREGIVER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OCT. 29, 20**1**2 4 Donation 5 Other (Specify) CEDAR HLL CMETERY SUITLAND, MD 21. Signature of Funeral Service Licensee THORNTON FUNERAL 3439 LIVINGSTON LYDIA C. THORNION JOHNSON/MO0583 INDIAN HEAD, MD 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician cardiac disease or condition u te Medical resulting in death) Due to (or as a consequence of): Examiner theroscleration leavs Sequentially list conditions, cause (Disease or injury Due to for as a consequence off or Attending Physician: The law requires that the death certificate be executed pertension that initiated events physician ar resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year ned by the a e detached t P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe 1 be a ۾ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy death? Yes 2 No 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No |၉ 1 DOA this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1. Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 11701

ddress of person who completed cause of death (Item 23a) (Type, Print)

· Herbert Washing

Day, Ye

31. Date filed (Month,

D22500

NUMBER

Rd #205 Ft

- Washington, WD 20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER HELEN MAY LOUK Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** CIVISTA MEDICAL CENTER PLATA 6. Sex If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) Funeral ocT.t.Pay,Yeg)19 1 □ M 2 F Director 226-24-4427 93 Yrs Usual Residence of Decedent 28a-f shov 10a. State 10c. City. Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 101 WESLEY DRIVE 20646 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify: 3XXWidowed 4 ☐ Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM B. SHIFFLETT MOLLIE LEE SHIFFLETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WESLEY DRIVE LA PLATA, MD 20646 SYLVIA HILL/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY MEM.GRDNS. 7, 2012 20a. Method of Disposition NOVEDMBER 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State WALDORF, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signatore of Funeral Service Licenses on M00641 5635 WASHINGTON AVE., LA PLATA, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Due to (or as a consequence of) disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 5 Other (specify) Pregnant at time of death detached d Unknown P.O. signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24a. Was an page 2 s autopsy performed? Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify)

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

20646

Approximate Interval Between Onset and Death

1 X Yes 2 No

VÍRGINIA

2012

CHARLES

S.

Month

Dav

24b. Were autopsy findings available prior to completion of cause of death?

2 🗌 No

1 Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

11-1-19

28d. Describe how injury occurred

Year

Black, White, etc.

WHITE

M

Division of Vital funeral director, completed filled in by the

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deat To the Funeral Director:

1 Yes

27. Manner of Death

Natural Natural

2 Accident
3 Suicide
4 Homicide

only one)

29b. Signature and title of certifier

29a. Certifier

ပ

Certificate:

Medical

2 **M** No

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4140 CM Machinga Bl Markor MD 30009 Titte any Gaines

28a. Date of injury (Month, Day, Year)

31. Date filed (Month, 2012

5 Pending Investigation

6 Could not be

determined

gary Cours ORDP

Registrar's Signati

1 Inpatient 2 ER/Outpatient 3 IDOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in ring opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

work

29c. License number

1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

VOID

CERTIFICATE

2012 - 37444

SEE

CERTIFICATE

2012-35226

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ NOVEMBER 7 2012 ear LINDA 5:57 MARIA LAMBERT Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Queen Anne's 222 E. Main St. Sudlersville Social Security Number If Under 24 Hrs 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 215-90-4626 47 oct 20 1965 Maryland Director 1 □ M 2 🏲 F Yrs Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Queen Anne's Sudlersville ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 222 E. Main St. U.S.A. 21668 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. O. Completed by 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Yes, Give "natural", 3 Widowed 4 Divorced Year or Dates 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. 12 Postal Carrier U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jack Dongarra Anne Trew 19a. Informant's Name/Relationship (Type, Print) Department of Health and Important: If item 27 is m any injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Lambert (husband) 222 E. Main St. Sudlersville, MD. 21668 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cometery, cremation (Nerplace)
Kent Cremation Services 11/13/12 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smyrna, DE. Galena Funeral Home of Stephen L. M00510 118 West Cross St. Galena, MD. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): physician Physician/Medical Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the at d be detached for g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy 2 X No ☐ Yes Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pendina 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

P.O. Records, Division of Vital Director: After To the Hospital within 24 hours a To the Funeral D

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew S. Ferguson, M.D. 120 Speer Rd. 31. Date filed 32. Registrar's Signature

786

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

Chestertown, MD. 21620

Medical

29a. Certifier (Check

only one) 29b. Signature and title of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #25, PER ME State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Hilda Oppha Hilda Willer

4a. Fadility Name (If not institution, give street and number) /Medical 4b. City. Town, or Location of Death 4c. County of Death Examiner Garret Hazorter Manun Counte 8. Date of Birth (Month, Day, Year) 9 / 25 / 1922 5. Social Security Number Age (In vrs. 9. Birthplace (State or Foreign last birthday Funeral 1 □ M 2 💢 F Months Days Hours Min Maryland Director 216-22-6772 Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evanians in state to recitive at Director 1 ☐ Yes 2 ☐ No Garrett Accident 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 591 Pud Miller Road 21520 U.S.A. Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: and 2 should be filed within 72 hours after 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bach Effie ည Henry Georg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Miller/ Husband 591 Pud Miller RD., Accident, MD 21520 permit. Pages 1 and:
Department of Health
Important: If Item 27
any injury or other tn
once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St Paul's Cem. 11/3/12 Accident, Maryland 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 179 Miller St., Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that shused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hyears OPT disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Jastolic Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-transi and CERTIFICATION AFFRONCED BY MEDICAL EXAMINER Due to (or as a consequence of) attending physician for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate | 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner/ 1X Yes 21 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □Yes 2 □ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature/and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) 12.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 417H S 00 31. Date filed (Month, Day, Year) 32. Registrar's Signature 7 Registrar

DHMH 17 Rev 1/2001

Wallace	Terrell	Maddox
ranaoo	1011011	ITIGGGOX

2-08548 Vallace Terrell	Mad	Please Type or Print in Black Indeli			ole.	
Vallace Tellell	IVIAU	1- For State Certifica	ent of Health and Mental Hy ate of Death	-	201	2 271.1.
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)	J. J. Douill	Reg. N 2. Date of Death		3. Time of Death
dedical Exami		Wallace Terrell Maddox		Month Da November 11	y Year , 2012	0141 hrs
and a second		Wallace Terrell Maddox 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
, ,		Civista Medical Center	La Plata		Charles	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	4	MM/DD/YYYY) 9. Birt Foreign	า
Director		213-17-5569 1∑M 2□F 27	Yrs.	Oct. 10,	1985 Mg	ryland_
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
<u> </u>		Maryland Calvert Lusby				1 Yes 2 No
vfaryland 28a-f show i at once.	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Coun	try?
215-0036 be filed within 72 hours after death with the Maryland ntal Hygeine. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	Ē	884 Crystal Rock Rd.	20657		U.S.A.	
with	era	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp		14. Race - Americ	can Indian, Black,
death or ite	Funera	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
s after ral",	þ	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:	1 Yes 2 No specify:		Specify: Bla	
2 hours afte "natural", Examiner	ted		Decedent's Usual Occupation (Give kind of working most of working life. DO NOT use retire.		b. Kind of Business/Ir	ndustry
36 hin 7. than edical	Completed		lumber Helper	-	Plumbing C	ompani
5-00 ed wit fygien other	ပ္ပ	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Maid	en Surname)	Omparry
	B	Paul Maddox	Sharon			
ID 21 should and Mer 7 is man	٩		D. Mailing Address (Street and Number or R			Zip Code)
adth 2			84 Crystal Rock Rd., of Disposition (Name of cemetery,		C. Location - City or	True Otata
Baltimore, permit. Pages 1 a Department of He Important: If ite		1 Burial 2 X Cremation 3 Removal from State cremate	ory or other place) Nov. 16	, 2012	•	
ti Pag trment rtant:			olitan Funeral Servi			, Virginia
Bal Permi Depar Impo		21. Signature of Funeral Service M00668	22. Name and Address of Facility Williams Funeral H 4270 Hawthorne Rd.	ome, P.A.		20.640
Physician	-	23a, Part I Enter he disease, or complications that caused the death. Do no	t enter the mode of dying, such as cardiac or	respiratory arrest,	Head, Ma.	20640 Approximate Interval
/Medical		failure. List only one cause on each line.				Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. MUITIPLE Blunt F3 Due to (or as a consequence of):	ice injuries			
	L	Sequentially list conditions, b				
	mine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
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876 tificat ng phy as the	W/C	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	Fetal death 3 Ectopic pregnal		23d. Date of delivery Month D	ay Year
ox 687 eath certific attending p	Si	4 Pregnant at time of death				
BO he deat the deat hed for	Physician/Med	9 Unknown				
ires that the signed by	by	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.		co use contribute to t	ably 4 Unknown
ords, w requires is been signatured by	ted		•	24a. Was an		opsy findings available
COF	Completed	-		autopsy performed	prior to c	ompletion of cause of
tal Rec	ပ္ပ			1 ✓ Yes 2		s 2 No
Vital ysician: his certifi director,	B	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Output ER/Output 26.Place of Death (Check of De		idence 6 Other		
n of V ding Phy After thi funeral d	<u>۱.</u>	27. Manner of Death 28a. Date of Injury 28b. 7				
ion tendin cath.	ertification:	1 Natural 5 Pending 11 (Month, Day, Year) 12 Pending 11 11-12	39 hrs 1 Yes 2 X No	auto that	while fle	eing law and ejected
VISI or Att fer de birecte in by t	fica	2 == Accident	irm, street, factory, office building, etc.	24 Licelli in (Stra	The William or to	senger of eing law and ejected run over by
Divipital or ours after Dirited in	Cert	4 Homicide determined (Specify) Roadwa		or Town, State Pomfret, M	Pomiret Ko	at Ray Rd.
e Hos 24 hc e Fun etely		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, dea				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	ledical	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.				
	Σ	29b. Signature and title of certifier	29c. License number	h.,	d. Date signed (Mor	
1		MM TIN	O.C.M.E.	N	ovember 11, 20	12
80-2		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner	900 W. Baltimore Street, Baltim	ore. MD 21223	3	
	ate	P			-	
Regist	rar	31. Date filed (MND Pay 1e3 2012 33 Registrar's Signature	gar			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Ma	aryland / Depa			lental Hygie	ne	0 77 1 1 0
		-	Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of De	eatn	Reg.	No.2	3/448
-AUE	Physicia Medi	cal	William Gordon McCann				8.4	8°, 2012 ear	3. Time of Death 6:30 P M
	Examir	ner	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L			4c. County of Death	
apart.	Funeral		5032 Nicholas Road 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth	Charles 9. Birth	place (State or Foreign
B	Director			75 Yrs.	Months Days	Hours Min.	(Month, Day, Yea		,,
	show show	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation		10, 10, 1		Od. Inside City Limits
	Maryla 28a-f	Funeral Director	Maryland Charles	Waldorf					1 ☐ Yes 2 🂢 No
	th the	a D	10e. Street and Number		10f. Zip Code		10g.	. Citizen of What Cour	ntry?
	ath wir	uner	5032 Nicholas Road 11. Marital Status 12. Was Decedent Ev	ver in IIS 13 V	20601 Was Decedent of Hisp	anic Origin? (Spe	offy Voe or No	USA	
9	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	by F	1 Never Married 2 M Married 1 Yes 2 N	↓o USN If	f Yes, specify Cuban,	Mexican, Puerto I	Rican, etc.)	14. Race - Americ Black, White,	
003	tural" al Exa		3 Widowed 4 Divorced If Yes, Give Year or Date 91	<u> 57-1964 </u>	Yes 2X No	, , ,		Specify: Whi	te
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21215-0036	within giene. er tha		Elementary/Secondary (0-12) College (1-4 or 5+	-)	Engineer			IBM	
pu	2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)				(First, Middle, Maid	-,	
Maryland	d Mer marke matic	-	Gordon McCann 19a. Informant's Name/Relationship (Type, Print)	100 14 10			Jean Coll		
	1 and 2 should be if Health and Men item 27 is marke other traumatic		Patsy L. McCann/ Wife		-			or Town, State, Zip (land 20601	
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	20b. Place of Dispos		1		. Location - City or To	
tim	nit. Page 1 artment of l ortant: If it injury or of		4 Donation 5 Other (Specify)	Huntt Cre				Waldorf, M	ID.
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee		Name and Address 35 01d Was		ıntt Fune Rd. Wald	ral Home orf, MD. 2	0601
			23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line.						Approximate Interval Between
22	Physician Medical		Immediate Cause (Final disease or condition resulting in death)	ty Cel	e le	uker	ME		Onset and Death
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_	cate be executed physician and the burial-transit	sal E	resulting in death) Last Due to (or as a	consequence of):					
3760	ficate g phys	Medical	d						
x 68	n certii ending	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of		Ectopic pregnancy			23d. Date of delive	ery
. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and real director, page 2 should be detached for use as the burial-transit	Physician/M	1	ime of death 5	Other (specify)			Month	Day Year
P.0	that the ned by e deta	by Pt	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause given	in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
ds,	equires en sig ould b						1 🗆 Yes	2 No 3 Prob	pably 4 STOnknown
COI	faw re has be ge 2 sh	Completed					24a. Was an autopsy	prior to coi	osy findings available inpletion of cause of
I Re	sician: The la certificate ha rector, page		25. Was case referred to medical		00 51		performed		2 🗆 No
Vita	is cert direct	To Be	examiner?	nt 2 ER/Outpatient	I au	e of Death (Check		6 ☐ Other (Specify)	
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sion	vttendi death ctor: A y the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	/ - At home, farm, stree	<u> </u>	s 2 🗆 No	Of Leasting (Street	and Number or Rural	Pouto Mumbou
Division of Vital Records,	al or A s after il Direction ed in b		4 Homicide determined 286. Place of injury building, etc.	(Specify)	et, lactory, office		City or Town, Sta		Houte Number,
	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of m	ımination and/or investi	gation, in my opinion,	death occurred at t	he time, date and pla	ace, and due to the cau	se(s) and manner stated.
	To the within To the comple	ı —	only one) 3 Certifying Nurse Practitioner: To the to 29b. Signature and title of certifier	rest of my knowledge, (29c. License nu			use(s) and manner as s Date signed (Month, L	
	, it		* F Madh		Dac	+35))	0 -31-1.	\
B	xxi		30. Name and address of person who completed cause of dea	719	Lat la	ta	Ms	206 41	ĵ
	Stat Registra	e ar	31. Date filed (Month, Day, Year) 32 Registrary	s Signature	de				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Mary Jane P. Miller $30^{\circ} 2012$ 07:00 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death Frederick Frederick Vindobona Nursing Home Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 579**-**44**-**7884 1 M 2 X F 77 Nov. 20, 1934 New York ?? Is marked other than "natural", or Itama 23a or 28e-1 sho treumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick 1 🗆 Yes 2 😾 No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6012 Jefferson Boulevard 21703 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hyglena. I other than * Elementary/Secondary (0-12) College (1-4 or 5+) Mail Room Clerk U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Vincent McCollom Anna Clair Morrissev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Haelth 624 Weverton Road, Knoxville, Maryland 21758 Kathleen Nichols / Daughter Baltimore, 20b. Place of Disposition (Name of St. Mary Star of the Sea Cemetery 20a. Method of Disposition Dapertment of Important: If I any Injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Unknown Lawrence, New York ²² Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 Fast Church Street, Frederick, 21. Signature of Funeral Service Laces 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Cimonic OBSTITULTIVE Physician/ disease or condition resulting in death) MMORALY Medical Due to (or as a consequence of): Examiner A THERW SCLENOSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin baan signad by tha attanding physician and should be datachad for usa as tha burlal-trensi Cause (Disease or injury AMYMGEAL that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records. Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an perform 2 No 1 🗌 Yes Division of Vital funaral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after daeth. 1 Natural 2 Accident 5 Pending ours aftar daeth.

leral Director: Af 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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State

Registrar

NUV

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #7 & #8 per FH FCHD TM 10/31/12
State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Phyllis Ann Mortenson October 28 2012 10:09A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 1942 Director 551-62-1686 1 □ M 2 🐼 F 70 71 Yrs Aug. 31, 1941 California filed within 72 hours are....tal Hygiene.
ed other then "natural", or items 23a or 28a-f show
ed other then "natural" or items 23a or 28a-f show
event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 Yes 2 No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7162 Glenmeadow Court 21703 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 XX No Specify: Completed 3 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Librarian Literature other treumatic event, Be 17. Father's Name (First, Middle, Last) should be file and Mental H is marked ot 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Raymond John Nicholson Dorothy Margaret Ausburn of Health and Me fitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cristin Tillinghast / Daughter 51 Deer Path, Torrington, CT 06790 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1: Department of I Important: If its eny injury or of Oct. Date 30 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resthaven Crematory 2012 Frederick, Maryland 21. Signature of Fune Service Lice see 22 Name and Address of Facility Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. Skkot Cody Frederick, P.A. MD 21701 23a. Part J. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final) Physician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use es the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) ed by the a q 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de Completed by 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 is autopsy 2 N No NIA 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 X ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 705 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 MD. 1564 OPOSS MUDOWN PIKE,

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 Bernice Ward Mills 19 2012 2:24 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 921 Cromwell Bridge Road Towson Baltimore 5. Social Security Number 244 78 3715 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Hours Min. **Director** 1 🗆 M 2 🛛 F 66 11/15/1945 MD at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director r 28a-f sl notified Baltimore MD Towson 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be 23a Funeral 921 Cromwell Bridge Road 21286 USA ral", or items a permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed Specify: Black 3 Widowed 4X Divorced Year or Dates ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Presser <u>Private</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I ဂ္ Simon Ward of Health and Menta item 27 is marked other traumatic e Mamie Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ward / Sister 921 Cromwell Bridge Rd. Towson, MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Goldsboro, NC Old Mill Cem. 10/27/12 Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd. Waldorf, 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ Myelodysplasia (High Grade) 10 Months Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trans Due to (or as a consequence of): attending physician Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death signed by the at d be detached for 1 Yes 245 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires I within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be Division of Vital Records, Breast Cancer Completed 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 XNC 2 🗆 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2**X** No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Injury at 28d. Describe how injury occurred 5 Pending work? 1 X Natural 2 Accident
3 Suicide Investigation 6 Could not be 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

6569

N.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Street Baltimore,

D41406

29d. Date signed (Month, Day, Year)

10/25/2012

MD 21204 Dr. Mandhu Chaudry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 26, 2012 Derrel1 Gene Med1ey 7:30 \mathbf{P}_{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death 6609 Cougar Ct. Charles Waldorf 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign 572-52-0787 1 **X** M 2 □ F **Director** 73 4/8/1939 Arkansas or 28a-f show notified at 10a. State 10c. City, Town or Location with the Maryland Director 10d, Inside City Limits MD Charles Waldorf 1 ☐ Yes 2 X No 10e. Street and Number 9 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 6609 Cougar Ct. 20603 USA death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iter edical Examiner Race - American Indian. Black, White, etc. by 1 Never Married 2 Married 1 X Yes Baltimore, Maryland 21215-0036 within 72 hours after 2 No Specify: White 1 Yes 2 XNo Specify: 3 Widowed 4X Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ge 1 and 2 should be filed within 72 hat of Health and Mental Hygiene.

If item 27 is marked other than "nor or other traumatic event, the Medi Elementary/Secondary (0-12) College (1-4 or 5+) 12 Safety_Training Supervisor Petroleum Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Claude Medley Thadie Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darrell J. Medley, II/Son 6609 Cougar Ct. Waldorf, Md. 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ± 5 ☐ Burial 2 Cremation 3 ☐ Removal from State Department of Important: If any injury or Brinsfield-Echols Crem. 10/29/2012 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) Signal ure of Funeral Service License 22. Name and Address of Facility Arehart-Echols Funeral Home, PA M00945 P.O. Box 567 LaPlata, Md. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one care in each line. Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical eauence of Examiner signs stally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year the g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate 1 Yes 2 No Be Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes Other: ုပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) funeral (28a. Date of injury (Month, Day, Year) 27. Magner of Death Certificate: 28b. Time of After t 28c. Injury at 1) Natural 28d. Describe how injury occurred iniury 5 Pending vork? 1 Yes 2 No Accident Investigation within 24 hours after deatl To the Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basil of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the basil of my knowledge goals and carried at the time, date and place and due to the cause(s) and manner stated. 29a. Certifier (Check e and title of certifie 29b. Signatu License rumber 29d. Date signed (Month, Day, Year,

Registrar
DHMH 17 Rev 06-2011

State

eath (Item 23a) (Type

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Merrit Lobert OCTOBER 25° 2012 11:19 PM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death LA PLATA CHARLES . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Days 1 👿 M 2 🗆 F Hours OCTOBER 11 KENTUCKY 86 10b. County 10c. City, Town or Location CHARLES **POMFRET** 10f. Zip Code 10g. Citizen of What Country? 20675 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces? 1 Yes 2 X No Specify. Specify: BLACK If Yes, Give Year or Dates 15. Decedent's Education 16b. Kind of Business Industry

Examiner CIVISTA MEDICAL CENTER Social Security Number 9. Birthplace (State or Foreign **Funeral** Director 314-20-7847 Usual Residence of Decedent at 10d. Inside City Limits Director 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified 1 📆 Yes 2 🗆 No MARYLAND 10e. Street and Number Funeral 8165 WARREN DRIVE 11. Marital Status þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) YEARS ADMINISTRATOR **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ROBERT MERRITT, SR. ALLENA MERRITT GRIZZARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN J. MERRITT / WIFE 8165 WARREN DRIVE, POMFRET, MARYLAND Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State TRINITY MEMORIAL GARDENS NOVEMBER 2,2012 WALDORF, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service L THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JOHNSON MOO583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine Due to (or as a consequence of it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Hospital or Attending Physician: The law requires that the death 24 hours after death. in the past 12 months? Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ sidney disease Diabeles Mellitm-I 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 5. Was calle referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Yes ဂ္ဂ 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) Time of 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending work?
1 Yes 2 No Accident Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10 se or geath (Item 23a), (Type, Print) on Blud, SteB, Gren Burnie, MD, 21061 Dr. Josjin Vazz

Registrar

Physician/

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 02:10 M MILLER Month 20 Y93 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSP1717 MONTGONHON OWEN MONTGOMERO GENERA Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Funeral If Under 24 Hrs. 8. Date of Birth Days Hours Min 164-52-5037 56 06/07/1956 Director 1 □ M 2 🔀 F Pennsylvania 28a-f show 10b. County 10a. State 10c. City, Town or Location the Medical Examiner must be notified at **Funeral Director** 10d. Inside City Limits Md. Montgomery Laytonsville 1 ¥ Yes 2 □ No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6513 Garden Grove Way 20882 U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian Black White etc Completed by 1 Never Married 2 XMarried 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Accounts Receivable Clk Payroll Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Thomas, Sr. Theresa Fitzgerald Jones of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6513 Garden Grove Way
Laytonsville, Md. Robert Miller (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any njury or ot Date 20c. Location - City or Town, State cemetery, crematory or other place)
Eden Cemetery 1 Burial 2 Cremation 3 Removal from State Collingdale Pa 11/3/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Latney's Funeral Home 6313 Georgia Ave.N,W GC0530 20011 Washington, 23a. Part 1. Enter the disease, or cyn plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 21898 Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) LEVKEMIN AUTE MYELOID burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 Unknown ed by the a 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? Yes 2 X No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital ျ 1 Tes 2 × No Other: 1 Inpatient 2 ER/Outpatient 3 IDQA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Af Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 💃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitionars to the control of the control of the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioners To the best of my knowledge. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) OCTOBOL 28, 2012 95M mpleted cause of death (Item 23a) (Type, Print) #500 KINSNGTON MD 2089 Y

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Novembe Gaither Elmer Moser Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Director 215-20-9212 1 X M 2 □ F 89 Sept.20, 1923 Maryland Usual Residence of Decedent 28a-f show 10b. County with the Maryland nan "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Frederick Myersville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11905 Harp Hill Road 21773 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Farmer Dairy Farm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Roger Jacob Edna Poffenberger Moser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Foster/daughter 11921 Harp Hill Road, Myersville, Maryland 21773 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Grossnickle BrethrenNov.16,2012 Myersville, Maryland 4 Donation 5 Other 504 Main Street 21. Signature of Funeral S 22. Name and Address of Facility Ricketts Funeral Home Myersville, MD 21773 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Immediate Cause (Final Onset and Death Physician/ Melumonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to (cras a consequence of): cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a ld be detached f Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Encuphalitis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Emphysema 24a, Was an cate has page 2: autopsy performe Hypertension this certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Yes 2 No 1 Mnpatient 2 ER/Outpatient 3 DOA funeral 27. Manger of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After injury 1 Natural 5 Pending work?
1 Yes 2 No 124 hours after death.

e Funeral Director: A sletely filled in by the fi Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one)

State

31. Date filed (Month, Day, Year) NQV 2 0 2012 32. Registrar's Signature Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

01

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Theresa T. Meagher a 2012 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Salisbury Wicomico 28175 Bishops Court Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) Funeral Hours (Month, Day, Year) Director 218-05-9551 92 10/16/1920 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show eny injury or other traumatic event, the Madical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c, City, Town or Location Director 1 🗌 Yes 2 😾 No Salisbury Maryland Wicomico 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21801 USA 28175 Bishops Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Completed by 1 ☐ Yes 2 XNo Specify. 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Retail 12 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theresa Schleicher George B. Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28175 Bishops Court, Salisbury, MD 21804 19a. Informant's Name/Relationship (Type, Print) Maureen M. Ramsey/Daughter Itimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/2/2012 Salisbury, MD Salisbury Crematory 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Ball 21. Signature of Fuperal Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Oration disease or condition resulting in death) Medical Due to (as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burlal-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No After this certificate 1 Tyes filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu Investigation
6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 165 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DUNK M CONSTAL Date filed (Month, Day, Year) NOV 0 2 2012 32. Registrar's Signature State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Morgan 03:30AM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Home evindale Nursing Baltimore 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia **Funeral** 8. Date of Birth (Month, Day, Ye Min 224-18-1122 9 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3702 Fernhill 21215 AVE USA death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces 1 Never Married 2 Married þ ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 72 hours after "natural", 1 ☐ Yes 2 No Specify: Completed 3 Divorced 4 Divorced Specify: Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Bethlehem 10 Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Morgan Wanda Jimmy Blackwell 19a. Informant's ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) leopatra Morgan Fernhill Ave Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Poplar Luwn Cemetery 11-21-12 Blackstone, VA 50044 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muhart w Howdes W.E. Hawkes & Son F. H., Inc. Blackstone, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARBIOMYOPATH Physician/ disease or condition Medical resulting in death) Examiner HEROSCLEROTIC VACICULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter

To the Funeral Director: After this certificate has been signed by the after the formal of in the past 12 months? Month Day Year 1 Yes 2 D 2 \square No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? MENTIA 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? performed' 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Certificate: To 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a Certifie 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and the of certifier 29d. Date signed (Month. Day. Year) PMYSIGAN MM D0064533 11-17-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINSALE GENERAL 2434 W. BEWEDERE AVE. BALTIMORE MD 21215 BABATUNAE. -AJANI M) 31. Date filed (Month, Day)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kathryn Virginia Morgan 2012 8:50 November Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death **Westminster** Carroll Lutheran Village Healthcare 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours (Month, Day, Year) 220-24-3331 **Director** 1 🗆 M 2 🔀 F Nov. 10, 1914 WV 28a-f shov 10a. State with the Maryland notified at Director 10c. City, Town or Location 10d. Inside City Limits Carroll Westminster MD 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 546 Wyndwood Dr. 21158 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mack U. Vincent Icie Huffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Ccde)
287 Bell Rd., Westminster, MD 21158 Linda A. Payne - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Dremation 3 Removal from State 11/13/2012 | Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremations 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA ne 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on Immediate Cause (Final On let and Death Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown be detached for Month Year Pregnant at time of death Unknown signed by 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy the Hospital or Attending Physician: The I hin 24 hours after death. the Funeral Director: After this certificate h death? perforn 25. Was case referred to predica Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 I Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🔲 Yes Accident Investigation the 6 Could not by Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determi within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 20

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / State of Maryland / Registrar	Department of Health and N Certificate of Death		2012 271.50
	Physicia	an/	Decedent's Name (First, Middle, Last) Barbara Ann Newlon	- Corumoute or Boatin	Reg. 2. Date of Death	3. Time of Death
,	Medic Examir	cal	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	November	Da 201 2 9:50 Р м 4c. County of Death
146			Allegany Health Nursing & Rehab	Cumberland		Allegany County
	Funeral Director		214-52-1735 1 DM 25 64	Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea March 13	g. Birthplace (State or Foreign Country) 1948 West Virginia
07	land show dat	Ιō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow WV Mineral County Ko			10d. Inside City Limits
	ne Mary or 28a-f notifie	Director	WV MITHERAL COUNTRY Ke	yser	140.	1 ☐ Yes 2XXNo
	n with the is 23a court be	Funeral	HC 72, Box 403	Citizen of What Country? ited States		
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: white
Maryland 21215-0036	within 72 hor giene. er than "nat , the Medic s	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+	ng	. Kind of Business Industry blic Safety	
yland	d 2 should be filed alth and Mental Hy 127 is marked oth r traumatic event,	To Be	17. Father's Name (First, Middle, Last) Floyd Carson Newlon	18. Mother's Name Anna	(First, Middle, Maide Louise C	en Sumame) Cummings
, Mar	und 2 shou lealth and im 27 is m her traum			o. Mailing Address (Street and Number or Rura 9385 Garrett Highway)	Route Number, City Oakland,	or Town, State, Zip Code) Maryland 21550
Baltimore,	. Page 1 a tment of H tant: If ite jury or otl		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Land Crematory 11/08	3/2012 Cu	Location - City or Town, State Mberland, Maryland
Bai	permit Depar Impor any in		21. Signature of Funeral Service Licensee T. Wayse Surl	22. Name and Address of Facility Boa 111 Church St, West	al Funeral ternport,	. Home Maryland 21562
į,	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final			Approximate Interval Between Onset and Death
Marie Contraction of the Contrac	Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of the consequen	OF THE LIVE	R	5 yes
		iner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	Dī):		
	ecuted and I-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as a consequence of the consequenc	of):		
09	icate be executed physician and sthe burial-transit	edical	d			
687	certifica nding pl	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
). Box 68	the death by the atter ached for u	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	h 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
ds, P.C	requires that the death certific been signed by the attending should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.		o use contribute to the cause of death?
Division of Vital Records, P.O.	he law tte has age 2	Completed			24a. Was an autopsy performed?	
/ital	Physician: 1 r this certifice rral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	26. Place of Deat (Check		
J of	ding Phy th. After this funeral c		27. Manner of Death 28a. Date of injury 28b. 1	Fime of 28c. Injury at work?	me 5 Hesidence 28d. Describe how inj	6 Other (Specify) ury occurred
Visior	r Attend ter death irector: /	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No rm, street, factory, office	28f. Location (Street a	and Number or Rural Route Number,
۵	spital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occured at the time, date and place, an		·
	thin 24 I	Medical	(Check 2 ☐ Medical Examiner: On the basis of examination and/only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge.	or investigation, in my opinion, death occurred at ledge, death occurred at the time, date and place	the time, date and place, and due to the cause	ce, and due to the cause(s) and manner stated. e(s) and manner as stated.
	7 W 7 00		29b. Signature and title of certifier Courtier Odway	29c. License number 0 - 14865	29d. C	JDV: 774 2012—
		10	30. Name and address of person who completed cause of death (Item 23a). Dr. R J Barrera, 200 Glenn St,	Jype, Print) Cumberland, MD 21502		
	Stat Registra		21 Data filed (Manth Four Year)	back		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 31 2012 12:15P M Betty M. Nutter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Wicomico Salisbury <u>Wicomico Nursing Home</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Hours Director 213-16-7884 1 🗆 M 2 🔯 F Yrs 90 Dec. 12, 1921 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Wecken Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ★ Yes 2 No MD Wicomico Salisbury 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 U.S.A. 133 Truitt Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give 3 ₩Widowed 4 ☐ Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 11 occupational therapist medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mack Bradley Hilda Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21804 Vicki Hoeben (Daughter) 8291 Arden Drive Salisbury, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mardela Memorial Cem. Nov. 3, 2012 Mardela Springs, MD 22. Name and Address of Facility
Short Funeral Home
13 E. Grove Street 21. Signature of Funeral Service Licensee Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☑ No **Division of Vital** 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and fittle of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 T-12-W MD 31. Date filed (Month, Day, egistrar's Signature State NOV 05 Registrar

DHMH 17 Rev 06-2011

Registrar

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Aquilla Mae Oester Medical 4a. Facility Name (if not institution, give street and number) c. County of Death Allegany 4b. City, Town, or Location of Death **Examiner** Cumberland WMHS Regional Medical Center 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Months 75 220-34-1487 Director 1 🗆 M 2 🏻 F March 8, 1937 Usual Residence of Decedent show 10c. City, Town or Location at Director notified 28a-f Garrett Grantsville MD 10e. Street and Number 10f. Zip Code items 23a or ner must be r 10g. Citizen of What Country? Funeral 21536 USA 2315 National Pike Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. "natural", or edical Examin ģ 1 Never Married 2 X Married 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) College (1-4 or 5+) Owner/Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Ith and Mental H 27 is marked of traumatic ever ပ Clara Pauli Albert F. Richter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route ge 1 and 2 sl it of Health a : If item 27 is 2315 National Pike, Grant Robert A. Oester/Husband other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Department o Important: If any injury or once. P John's Luth. Cem. Nov. 8, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Newman P.O. Box 275, Grantsvi euma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respi shock, or hear failure. List only one cause on each line Immediate Cause (Final Physician/ EXTRAMEDULLARY disease or condition resulting in death) MYGLOMUNOCYTIC Medical Due to (or as a consequence of **Examiner** HIRUNIC MYELOMONOCYTIC Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the at Id be detached for Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23 þ Division of Vital Records, Completed 2 has page 2 To Be 25. Was case referred to medical 26. Place of Death (Check only o examiner? Other: 2 No 1 Minpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. De Hospital or Attending 1 Natural 5 Pending s after death. 1 Yes 2 No Accident
Suicide Investigation filled in by the 6 Could not be

		Owner/Operato	or	R	etail	
Middle, Last) Richter			18. Mother's Name Clara Pat	(First, Middle, Maid uline McC		
Relationship (Typ	e, Print)	19b. Mailing Address (Street	and Number or Rural	Route Number, Cit	y or Town, State, Z	ip Code)
ester/H	lusband	2315 National	l Pike, Gra	antsville	, MD 21	536
1		lace of Disposition (Name of emetery, crematory or other pla	D	ate 200	c. Location - City o	r Town, State
mation 3 ∐ F Other <i>(Specify)</i>		John's Luth.	Cem. Nov.			
rvice License	leuman		ess of Facility News 275, Grants			
e. List only one	e cause on each line.	n. Do not enter the mode of dyi				Approximate Interval Between Onset and Death
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te 🍠	Due to (or as a consequ	ence of):				
	Due to (or as a consequ	ence of):				
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. 25	3c. If yes, outcome of pregnar	ncv				
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	4 ☐ Pregnant at time of d 9 ☐ Unknown	eath 5 U Other (specify) _			MOITER	Day real
				1		
onditions con	tributing to death but not resu	ulting in the underlying cause g	iven in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
				1 🗆 Yes	2 🗐 No 3 🗆 F	Probably 4 Unknown
				24a. Was an	24b Were a	utopsy findings available
				autopsy performed	prior to death?	completion of cause of
edical		26. F	Place of Death (Check			
H	ospital:		ner: 4 Nursing Hon		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-75.3
		28b. Time of 28c. Inju	4 □ Nursing Hon	8d. Describe how in	o b Utner (Spe	CITY)
Pending Investigation	(Month, Day, Year)	injury wor		od. Describe now ii	ijary occurred	
Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street, factory, office	2	8f. Location (Street City or Town, St	t and Number or Ru ate)	ural Route Number,
dical Examine	er: On the basis of examination	edge, death occurred at the tim and/or investigation, in my opin y knowledge, death occurred at	ion, death occurred at t	he time, date and pl	ace, and due to the	cause(s) and manner stated
200		29c. Licens			Date signed (Mont	
W.	· wo	000	73417	No	VEMBER	6,2012
	mpleted cause of death (Item	168 NATIONAL	HCG-INVA!	- Lava	CE MANT	cans 2150.
Year) B 2012	32. Registrar's Signat	ball ball				
J LUIL	CENTRAL P.	4	<u> </u>			

3. Time of Death

9. Birthplace (State or Foreign

10d Inside City Limits

1 Yes 2 X No

Maryland

Registrar

24 hours

To the 1 within 2 To the 1

Medical

29a. Certifier

only one 29b. Signature and title

31. Date filed (Month, Day, Year) NOV - 8 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1068 NATIONAL AMET R-MOUN. MA /32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylar		artment of F <i>rtificate of L</i>			giene 2 0	12 37463	
	Physicis	m/	Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death	
	Physicia Medio	al_	Oranie Pierre-Lou					Month Septe	mber 15,	Year 2012 0930 M	
	Examin	er	4a. Facility Name (if not institution, give stre	,		4b. City, Town, or		eath	4c. County of		
a sant	Funeral		Salisbury Rehab + 5. Social Security Number 6. Sex	7. Age (In yrs.		Salisbu If Under 1 Year	If Under 24 F			9. Birthplace (State or Foreign	
	Director			12⊠F 89	Yrs.	Months Days	Hours M	tin. (Month, Da 12/10		Country) Haiti	
b	how	۱	Usual Residence of Decedent 10a. State 10b. County	10c, C	ity, Town or Lo	ocation		12/10	7 1 7 2 2	10d. Inside City Limits	
Aarvla	8a-fs	Director	MD Wicomico	5	Salisbu	ıry				1 ☐ Yes 2🌠 No	
the	a or 2 be no	٥	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?	
÷ ×	ns 23 must	Funeral	211 Morris Dr.		Hai	ti					
036 s after deal	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<u>آ</u>	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 TNo If Yes, Give Year or Dates.		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🖾 No	n, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	Yes or No- an, etc.) 14. Race - American Indi- Black, White, etc. Specify: Haitia		
5-0 Pour	'natur dical	plete	15. Decedent's Educa (Specify only highest grade of	tion		dent's Usual Occupa		working	16b. Kind of Bus	siness/Industry	
121 This 2	than than	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. L	OO NOT use retired)	anng most or v	WOIKING	67		
0 3 E	Hygie other ent, th	Be	17. Father's Name (First, Middle, Last)		Se	amstress	18. Mother's I	Name (First, Middle,	Cloth Maiden Surname)		
//an	Jental arked tic ev	잍	Alcinois Pierre-Lou	is				ınise Sain	,		
Maryland 21215-0036 should be filed within 72 hours after	is me		19a. Informant's Name/Relationship (Type,	•	19b. Mail	ing Address (Street a	and Number or	Rural Route Numbe	r, City or Town, St	ate, Zip Code)	
e, ⊾	Health em 27 ther t		Ernst Pierre-Louis 20a. Method of Disposition	·		New York	Ave.,	Salisbury			
TOL 30e 1	ant of nt: If it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	cemetery, cre	matory or other plac	· •	Date		City or Town, State	
Baltimore, permit. Page 1 and	partm portal y injul		21. Sign tue of Funeral Service Licensee			Cemetary 2. Name and Addres		09/22/201		oury, MD	
m 8			16di			UI Snow H	<u>ill Kd.</u>	<u>, Salisbu</u>	<u>ry, MD 2</u>	ll Associates	
,	ysician/ Medical xaminer		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one commediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as a consec	clert			La Disc		Approximate Interval Between Onset and Death	
executed	physician and s the burlal-transit	Examiner	If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec							
60 ate be	ohysici the bu	edical	d	= .		. <u>.</u>					
), BOX 68760 he death certificate be executed	ed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregn 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3	☐ Ectopic pregnanc☐ Other (specify)	у		23d. Date Mon	e of delivery th Day Year	
cords, P.O. law requires that the	n signed b	2	Part II. Other significant conditions contril	outing to death but not re	sulting in the	underlying cause giv	en in Part I.			bute to the cause of death? 3 □ Probably 4苍 Unknown	
e e	ate has page 2	Completed						24a. Was autop perfo	osy pr rmed? de	vere autopsy findings available rior to completion of cause of eath?	
ta	sertific ector,	Be	25. Was case referred to medical examiner?	pital:			1	Check only one)			
Phys C	r this e	<u>ان</u>	1 Li Yes 2 tv No	1 Inpatient 2 28a. Date of injury	ER/Outpatie		4 A Nursin	g Home 5 Resid	dence 6 Other		
	ath, r: Afte ne funi	icat	1 🔀 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	work'		Zod. Describe ii	ow injury occurred		
DIVISION OF tal or Attending Pt	rs after de al Directo led in by tl	l Certificate:	4 C Homode determined	28e. Place of Injury - At h building, etc. (Specif	5)			City or Tow	n, State)	r or Rural Route Number,	
the Hospi	within 24 hours after death, To the Funeral Director: After this certific, completely filled in by the funeral director,	Medical	only one) 3 L Certifying Nurse Pr	On the basis of examination	on and/or inves	stigation, in my opinio	n, death occurre	ed at the time, date a	nd place, and due	to the cause(s) and manner stated.	
Ę	To Con		29b. Signature and title of entifier		>	29c. License	number	9	29d. Date signed	(Month, Day, Year)	
			30 Name and address of person who comp	leted cause of death (Iter	m 23a) (Type,	Print) City	e Ave	Salis	buy,	~D 21804	
	Stat Registra		31. Date filed (Month, Pay, Year) 1 201	2 32. Pégistrar's Signa	ature g.	barker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month /O 20/2 PARRISH WILLIAM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BRIDHAL MODERAL SAUSBULU HICOMICO 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Country) Director 263-50-8399 77 1 X M 2 □ F AUG. 20, 1935 FLORIDA 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND WICOMICO 1 Yes 2 No WILLARDS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7592 GREEN LEWIS ROAD 21874 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 K Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Completed 3 Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) i Hygiena. I other then " vent, the Mer Elementary/Secondary (0-12) College (1-4 or 5+) MEAT CUTTER **GROCERY** Be umatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mentail မ PARRISH WILLIAM SETH ALBERMAN EVELYN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 NANCY L. PARRISH/DAUGHTER 7592 GREEN LEWIS ROAD, WILLARDS, MD 21874 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Dapartment of I Importent: If Its eny Injury or of 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) CREMATORY OF DELMARVA 10/30/12 DELMAR, DELAWARE 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused to leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENDO CARDITIS Physician/ ease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death), as the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions, in the conditions, in the conditions, if any leading the conditions, if any leading the conditions, if any leading the conditions, if any leading the conditions, if any leading the conditions, if any leading to immediate the conditions of t Examiner To the Hospital or Attending Physician: The iaw requires that the death certificata be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signad by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant Box 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Yes 2 No 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔏 No Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} မှ 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year, 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D-71972 10/29/12 465 dress of person who completed cause of death (Item 23a) (Type, Print) VAI Shaik Abdul, 951 A. Mt. HERMON RD,

Registrar

State

31. Date filed (Month, Day, Year,

3

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edward anch 0615 Parker Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Baltimore Hospita If Under 1 Year If Under 24 Hrs. **Funeral** Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8 Date of Birth (Month, Day, Year) 227-20-7763 **Director** 1 ≥ M 2 □ F 1928 Feb 12. Virginia or 28a-f show 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at Funeral Director Maryland hoenix 1 X Yes 2 No timore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a (2820 Pa 14.11 21131 USA or items 11. Marital Status 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1950 - 1952 and Mental Hygiene. is marked other than "natural", 1 Yes 2 No Specify: Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ပ Harker harlie injury or other traumatic Annie Hawkes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Parker Evelyn St. NIECE Taylor Blackstone. VA 23824 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2012 Blackstone, VA edar Hill Ch. Cemetery Nov. Signature of Funeral Servige Licenses 22. Name and Address of acility W.E. Hawkes & Son Funeral Home Blackstone, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition dvances Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-tra resulting in death) Last Due to (or as a consequence of): physician Be Completed by Physician/Medical attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 1 Yes 2 L 9 Unknown the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown director, page 2 should 1 Nes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 1 Yes 2 No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify filled in by the funeral 28a. Date of injury (Month, Day, Year) re Hospital or Attending Pl n 24 hours after death. Ie Funeral Director: After th Certificate: 27. Manner of Death 28h Time of Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title o MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 201

CRICHLOW MO

NOV 2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State Registrar	State of Maryla		artmen rtificate				ı	Reg. No.	012		
Physici /Medi		1. Decedent's Name (First, Middle, Last) Howard O. Pucke							2. Date of Dea Month Oct.	31	2012	3. Time of Death	
Examir	ner	4a. Facility Name (If not institution, give s. 13322 Pruitt Lane	9		Pr	ince	Location of SS A1	nne	O Date of Birth	Sc	merset		
Funeral Director	-22	5. Social Security Number 6. Sex 231–50–8733	7. Age (In yr	s. last birthday) Yrs.	If Under Months	Days	Hours	Min.	8. Date of Birt (Month, Da May 24	y, Year)	Coui	place (State or Foreign ntry) ginia	
hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	ō	10a. State 10b. County MD Somerset		City, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
or 28a-	Funeral Director	10e. Street and Number		TIMECSS	10f. Zip				Т	10g. Citizen	of What Cour	ntry?	
ath wil	ral	13322 Pruitt Lane				2185					ed Sta		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naturali", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Neyer Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		was Deced if Yes, spec		Specify:		ecify Yes or No Rican, etc.)		Black, White,	etc.	
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Hygiel ther th		17. Father's Name (First, Middle, Last)			armer		18. Mothe	er's Name	(First, Middle,		<u>icultu</u> mame)	re	
rked o	To Be	Howard O. Puc	kett Sr.				Ne1	llie	Anthony	Puck	ett		
and w is mai		19a. Informant's Name/Relationship (Typ	•		9	•			al Route Numb			Code)	
em 27	1/2	Victoria Collins 20a. Method of Disposition	Daughter 20b	. Place of Dispo	sition (Nan	ne of	i		ncess A		MD on - City or To	21853 own, State	
y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cre Salisbu	matorý or o ry Cr	ther plac emat	ory 1	1/05	/12		sbury,		
Importar any injur once.		21. Signature of Funeral Service License		295	2. Name an	d Addres	ss of Facili	ity Hi	nman Fu • Princ	neral	Home		
ysícian		23a. Pagh. Enter the disease, or complic spock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.		ter the mod	e of dyin	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
Medical caminer		resulting in death)	Due to (or as a cons						1			/	
nd ransit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to or as a cons	equence of):									
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/ the attending phy ched for use as the	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf preg 1 □ Live birth 2 □ Fi 4 □ Pregnant at time o 9 □ Unknown	etal death 3[⊒Ectopic pi ⊒ Other (sp		/			23d	. Date of deliv Month	ery Day Year	
been signed by the should be detached	d by Phys	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	inderlying c	ause giv	en in Part	l.				the cause of death?	
s certificate has beel irector, page 2 shou	Completed								24a. Was auto perfo		prior to co death?	opsy findings available ompletion of cause of	
is certifica director,	Be	25. Was case referred to medical examiner?	e Til			Loub		e of Deat	h (Check only o	one)			
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r: After e funere	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year,) Injury	М		ƙ? Yes 2.⊑						
To the Funeral Director: completely filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spe	ecify)					City or To	wn, State)		al Route Number,	
Funer etely fill	Medical	29a. Certifier (Check only one) Check only one) Check only 2 Medical Examination	sician: To the best of my kner: On the basis of exam and manner stated.	knowledge, dea ination and/or in	th occurred nvestigation	at the tir , in my c	me, date a opinion, de	nd place, ath occur	and due to the red at the time	cause(s) an date and pl	d manner as ace, and due	stated. to the cause(s)	
To the Fun	Me	29b. Signature and title of certifier			29	c. Licens	e number				igned (Month		
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1		30. Name and address of person who co				- 11.			A D-			MD 21809	
St	ate	31. Date filed (Month, Day, Year) NOV 0 5 20	32. Registrar's Sig		1665	W	000 G	ROO	c Ne	~ ~	135 ORY	V. 5 C. 609	
Regist		NUV 0 5 20	12 12	6	1								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dean Wade Price October 27, 2012 11:38 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Country Meadows Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 214-16-1839 92 Director 1 XM 2 | F Aug 30, 1920 Maryland ed other than "natural", or items 23a or 28a-f show event, the Medical Exeminer must be notified at 10b. County 10c. City, Town or Location Director 10d Inside City Limits Virginia Prince William Gainesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13672 Paddock Court 20155 USA 12. Was Decedent Ever in U.S. Armed Forces? 1½ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 Divorced Specify Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 College (1-4 or 5+) Elementary/Secondary (0-12) Executive Communications 1 and 2 should be filed within the fleath and Mental Hygiens item 27 is marked other the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Willie Price Rena Victoria Kinna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki Wallace - daughter 7605 Laurel Leaf Drive, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of H cemetery, crematory or other place, Stonewall Memorial 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-5-2012 4 Donation 5 Other (Specify) Manassas, Virginia 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Due to (or as a consequence of) Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) slcien and burlal-transit Due to (or as a consequence of): resulting in death) Last ed by the attending physicien detached for use as the burla Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown ☐ Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires th within 24 hours after death.
To the Funeral Director. After this certificate has been signe completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) A 351 54PO ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one title of certifier 29b. Signature 29c. License number 15x redence on px1202 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

5406

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Shirley Mae Rose 2012 October 0 :06 Α. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Dove Hospice House Carrol1 Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months Hours (Month, Day, Year) 01/13/1931 Director 1 M 2 X F Pennsylvania 095-28-7500 Usual Residence of Dece 81 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Carrol1 Mt. Airy 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21771 United States 711 Band Shell Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. <u>م</u> 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) rould be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Maxwell Newton Pearl Bogenrief 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 711 Band Shell St., Mt. Airy, MD 21771 Herman Rose / husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 11-1-2012 4 ☐ Donation 5 ☐ Other (Specify) Highland Cemetery New Columbia, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. gayelen 8 E. Ridgeville Blvd., Mt. Airy, MD 21771 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sician and burial-transit Exami Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant Pregnant at time of death 5 Other (specify) Month Day n signed by the a Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should the strong that the strong the strong that th Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed! Yes 2 No 2 🗌 No 1 Yes **Division of Vital** æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence မ 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 5 Pending 1 🔲 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Y 8

State Registrar filed (Month, Day, Year

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State RegistrarAmend #17 19a & 19 Ceptificate pf Death 1/7/12 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death October Physician/ 12:45PM awrence Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FUTURE CARE NURSING HOME CLINTON PG 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Days Months Hours Country) 216-86-7904 Director 1 X M 2 □ F Yrs. 2-9-1964 48 1 end 2 should be filed within 72 hours efter deeth with the Merylend of Heelth end Mentel Hygiene.
I flem 27 is merked other than "neture!", or items 23e or 28e-f show other treumetic event, the Medical Examiner must be retified at 10h Count 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD PG SUITLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3515 SILVER PARK DRIVE, #303 20746 US Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ۾ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify:BLACK 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) $\begin{array}{c} \hbox{Elementary/Secondary (0-12)} \\ 11TH \end{array}$ College (1-4 or 5+) SANITATION EMPLOYEE PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JENLINE TOLSON JERLINE TOLSON CLEARENCE MOORE 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address Street and Number of Filtral Route Number City or Jown, State, Zio Code) 23308 BANNEKER BLVD, AQUESCO, MD 20608 23308 BANNEKER BLVD, AQUESCO, MD 20608 LEATRICE ADAMS Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pege 1 e Depertment of H Importent: If Ite eny Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11-3-2012 WALDORF, MD POPE FUNERAL HOMES, P.A. HERITAGE MEMORIAL 21. Signature of Funeral Service Lic 22. Name and Address of Facility 401085 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 P 1. Inter the disearch, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ hronic Reso disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner raumati Sequentially fist conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ettending physicien end for use es the burlai-transi Yotor Vehic death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) 4 Pregnant at time of death signed by the et d be detached for 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Hospitel or Attending Physicien: 盎 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 👟 7 28c. Injury at 1
Natural 5 Pending ours efter deeth. erel Director: Af filled in by the fu Usucalar 30. 1 Yes 2 No 2 Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stat. 29a. Certifier completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number D005333 2012 35m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9106 Pineview Lane egistrar's Signatur State Registrar

12-08093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Dennis Lee Roa	aCII	1- For Stata Registrar		tate of Maryla		paπment o Certificate o		na ivientai	R	eg. No. 20	12 3747	
Physic Medical Exam		1. Decedent's Nam Dennis I							2. Date of Dea Month October 2	Day Year	3. Time of Death 1308 hrs	
		4a. Facility Name (on, give street and nu	imber)		4b. City, Town, o		eath	4c. County of Baltimore		
Funeral		5. Social Security I	Number	6. Sex		s. last birthday)	If Under 1 Ye	ear If Under 24	h.4:	rth (MM/DD/YYYY)	Birthplace (State or Foreign	
Director		213-34-5 Usual Residence of		1 M 2 F	75	Y	Months Da	ys Hours	Min. 02/22/	/1937	Country) MD	
* any		10a, State	10b. County		10c. C	ity, Town or Loca	ation				10d. Inside City Limits	
ryland a-f sbort	ţġ	MD 10e, Street and Nu	Balt:	imore		Woodsto	CK 10f. Zip Code		11	0g. Citizen of What	1 Yes 2 No	
the Ma ha or 28	Director	2930 Her		Road				1163		USA		
ath with items 23	Funeral	11. Marital Status 1 Never Marri	ed 2 🔽 N	Married Armed F		1054 If		lispanic Origin?	(Specify Yes or No erto Rican, etc.)		American Indian, Black, etc.	
after de	by Fu	3 Widowed	4 🗌 Di	vorced If Yes, Give Yea or Dates:		– 1958 ₁□	Yes 2X N			Specify:	White	
2 hours "natur	eted I	15. Decedent's Elementary/Sec		ecify only highest grade College (*			ent's Usual Occupa most of working lif			16b. Kind of Busin	ness/Industry	
0036 within 7 iene. ner than Medica	Completed	12				Police	e Office				imore City	
215-1 pe filed nal Hyg ked oth	Be Co	17. Father's Name Homer Le	,						ame (First, Middle, Rose Mull			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	ဥ	19a. Informant's Na Patricia					- ,		or Rural Route Nur , Woodsto	mber, City or Town,	State, Zip Code)	
re, M 1 and 2 Health fitem 2		20a. Method of Dis	position	n 3 X Removal fr			sition (Name of co		Date		city or Town, State	
Baltimore, permit. Pages I an Department of Hee Important: If ite		4 Donation 5	Other S	pecify:	E E	vergree	n Cemete:		0/31/12	Gettysbi	urg, PA	
Bali permit Depar Impon injury	Į Į	21. Signature of Fu	neral Service	Licensee		4:	Name and Addres 12 Washij	ss of Facilityr: naton Ro	itts Fune oad. West	ral Home minster,	and Chapel	
Physician Medical		23a. Part I. Enter the failure. List on				ath. Do not enter	the mode of dying	g, such as cardia	ac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and	
Examiner		Immediate Cause (or condition resulti		Due to (or as a							Death	
	er	Sequentially list co if any, leading to in		b. Due to (or as a	consequenc	e of):						
	Examiner	Coisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
60, tte be executed hysician and e burial - transit				d								
60, ate be exhysician by sician e burial	Wedical	UNPENDED		AMENDED 23c. If yes,	outcome of pr	egnancy				23d. Date of de	elivery	
certific certific ending p	cian/I	23b. Was decedent past 12 months	pregnant in t ?	he 1 Live b		2 F	etal death 3	Ectopic pre	gnancy	Month	Day Year	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/N	1 Yes 2 I		known 9 Unkno				given in Bort I	230 Did to	phacea uso contribu	ite to the cause of death?	
P.O. res that to signed by be detace	Ą	Part II. Other signi	ncant condi	contributing to	death but no	or resulting in the	underlying cause	giveri ii Farti.			Probably 4 Unknown	
ords w requi as been	Completed								24a. Was autop	sy prio	ere autopsy findings available or to completion of cause of	
Rec: The la		OF Management					26 Place	e of Death (Che	1 Yes	rmed? dea 2 No 1 ⊌	ath? Yes 2 No	
Vital bysician this cert	To Be	25. Was case refer examiner? 1 ✓ Yes	2 No	Linesitely -	npatient 2	ER/Outpatier				Residence 6	Other: Scene	
nn of nding Pl h. : After e funeral		27. Manner of Deat	h 5 Pen	28a. Date (Month FOUND		28b. Time of FOUND:		ury at Work? Yes 2 ✔ No	28d. Describe i Subject sho	how injury occurred t self		
ViSiC or Atter fter deat Director	Certification:	2 Accident 3 Suicide	Inve	stigation Oct 25,		1255 hrs t home, farm, stre	eet, factory, office		28f. Location (S		or Rural Route Number, City	
Oi cospital hours a uneral I		4 Homicide		hysician: To the bes	Farm/Ra		urrad at the time of	data and place	2930 Hernwo	od Road, Woodsi		
Divi; To the Hospital or ≠ within 24 hours after To the Funeral Dire completely filled in b	Medical	one) 2	Medical Exa	minar:On the basis of and manner s	of examination							
	ž	29b. Signature and	title of certifi	11, -11.	/ "	,		se number	OCME	29d. Date signed October 26, 2	(Month, Day, Year) 2012	
14 lu				who completed caus		•						
		Theodore N 31. Date filed (Monta						more Street	Baltimore, MI	21223		
ى Reais	tate	NOV 1	9 201	2 /2	gisti di Solgii	aturg						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3/4/ Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Claude Talmadge Selby, Sr. Month 11:08 A M Medical November 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1231 Friendsville-Addison Road Friendsville Garrett Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Nov 25, 1927 **Funeral** 9. Birthplace (State or Foreign Months Days Hours Director 215-24-3002 1 X M 2 □ F 84 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Garrett Friendsville 1 ☐ Yes 2 🛭 No ā 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1231 Friendsville-Addison Road 21531 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give 1 ☐ Never Married 2 🔀 Married Black, White, etc. ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Erector Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Elizabeth Humberson Ernest Selby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 1231 Friendsville-Addison Rd., Friendsville, MD 21531 Ina Jean Selby/wife permit, Pege 1 and 2 Department of Health Importent: If Item 27 eny Injury or other ti 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gardens Nov 14, 2012 Bel Air, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. 179 Miller St., Grantsville, MD 21536 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Immediate Cause (Final Onset and Death enysician/ Congestive Heart Failure disease or condition weeks Medical resulting in death) Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami or Attending Physicien: The law requires that the death certificate be executed the attending physician end thed for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant 9 Unknown Pregnant at time of death Year s certificate has been signed by the slirector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🖁 No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Cher (Specify) P 1 🗌 Yes 2 😾 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

and Range

31. Date filed (Month, Day

NOV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H-26154

Nov 9, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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	State of Maryland	/ Donartment of I	Health and Ma	ntal Hygians
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State of Maryland / Department of Health and Mental Hygiene		2012	37472
Certificate of Death	Pea No	2012	01416

		Registrar			(ertificate	Of i	Death					Reg. No).	l line	
Physician edical Examine	.,	1. Decedent's Name (F Carl Edwa		•								Date of D Month October	Dav	Year	r	3. Time of Death 1135 hrs
		4a. Facility Name (if no 7225 Sangrun		e street and n	umber)		4t	b. City, Tow McHenr		ocation of D			-	c. County o	f Death	
Funeral	1	5. Social Security Number	ber 6. Se	×	7. Age (In y	rs. last birthday)	If Under 1	****	If Under 2		8. Date of	Birth(MN	M/DD/YYYY)		hplace (State or
Director		216-22-66		M 2 F		84	Yrs.	Months	Days	Hours	Min.	Aug.	29,	1928	Foreig Cou	untry) Maryland
any	H	Usual Residence of De 10a. State 10b	cedent c. County		10c. (City, Town or Lo	catio	n								10d. Inside City Limits
ě	٥	MD	Garrett	:	Mo	Henry										1 Yes 2 No
and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. Item 27 is marked other than "matural", or items 23a or 28a-f show a traumatic event, the Medical Examiner must he notified at once.	Director	10e. Street and Numbe 7225 Sang		i.				10f. Zip Co 215					_	tizen of Wh	at Coun	itry?
th with tems 23a	L	11. Marital Status 1 Never Married	2 Married		cedent Ever i	n U.S. 13.				anic Origin? Mexican, Pu			No-	14. Race White		can Indian, Black,
fter deal				1 X Yes	2 N			Yes 2X				,,		Specify:		te
21215-0036 Mental Hygiene. marked other than "natural", e event, the Medical Examiner	- 69 - 69	15. Decedent's Educa	ation (Specify or	nly highest gra	ide completed) 16a. Dece				n (Give kind				Kind of Bus		,
hin 72 e. than "	Completed	Elementary/Seconda	ary (0-12)	College (1-4 or 5+)			Drive				,		arrett oads I		rtment
5-0036 lled within 7. Hygiene. I other than the Medical		17. Father's Name (Firs								3.Mother's N				n Surname)		
21215-003 ould be filed within Mental Hygiene. marked other tile event, the Med		Everett S 19a. Informant's Name/	_	vpe, Print)		19b. Ma	ilina A	Address (lary R				City or Town	State	Zin Code)
and 2 shou lealth and N tem 27 is n traumatic		Darrell A	A. Savaç			6934	1 S	ang R	un	Rd.,			MD	2154	1	
		20a. Method of Disposit		Removal f	rom State	b. Place of Dis crematory o	othe	er place)				ate		Location -	•	
Baltimore, permit. Pages 1 as Department of He Important: If it injury or other tr	-	4 Donation 5 21. Signature of Funera		see		ak Grov		Cemet me and Add	_					McHenr		MD , P.A.
		D'Leu		mae	7	E	.0	. Box	27	5, Gr	ants	svill	e, M	1D 21	536	, r.A.
Physician // /Medical		23a. Part I. Enter the dis failure. List only or	ne cause on ea	ch line.											rt	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Fina or condition resulting in		Due to (or as a		sclerotic Ca e of):	raio	vascular	Dise	ase com	plicate	ea by Hy	potne	rmia		Dodas
à		Sequentially list condition	diate I	Due to (or as a	a consequenc	e of):										
led nsit	Karm	cause. Enter Underlyin (Disease or injury that in events resulting in deat	initiated ^{C.} -	Due to (or as a	a consequenc	e of):						-				
7 0 6		UNPENDED	d	AMENDED		. <u> </u>										
8760, ificate be exect by physician and the burial - true the buri		F FEMALE:			outcome of p	regnancy			_		_		23	3d. Date of o	lelivery	
Box 68760 e death certificate b the attending physical for use as the bu	2	3b. Was decedent preg past 12 months?	gnant in the	1 Live		2		I death		Ectopic pre	egnancy	,		Month	•	ay Year
). Box 6i the death cert by the attendii ched for use a	Jan L	1 Yes 2 No 9	Unknown	· L		5	Othe	er (Specify)								
ords, P.O. Box 68' w requires that the death certifi is been signed by the attending should be detached for use as:	3	Part II. Other significar	nt conditions	contributing to	o death but n	ot resulting in th	e uno	derlying cau	use give	en in Part I.		_				he cause of death?
Records, The law requires fificate has been sig page 2 should be	212							<u></u>			_	24a. Wa	s an	24b. W	ere aut	opsy findings available
of Vital Records, ng Physician: The law requir ufter this certificate has been s meral director, page 2 should t n: To Be Completed											_		opsy formed? 2 1	de	ath?	empletion of cause of
ician: The certificate rector, page	3 2	25. Was case referred to						26.P		f Death (Che	eck only	one)				
Vita hysici this c	٥l	examiner? 1 ✓ Yes 2	No H		Inpatient 2	ER/Outpati	ent :	3 DOA	Ot	ther ₄ Nu	ursing H	ome 5	Resid	ence 6 🗸	Other:	Scene
on of sading Phrath. or: After the funeral		27. Manner of Death 1 Natural 5		28a. Date FOUND		28b. Time FOUND: 1130 hrs	of Inju			at Work? s 2 ✔ No	IQ11			to the co		vironment
Division o spital or Attending tours after death. neral Director: After fulled in by the fune Certification:	2	2 🗹 Accident 3 🗌 Suicide 6	Investigation Could not be	28e. Plac	e of Injury - A	t home, farm, s		factory, offi	ice buil	lding, etc.	281	f. Location or Town,		and Number	or Rur	al Route Number, City
2 = = -	- 14	4 Homicide	determined	(-		amily Home		ed at the time	o data	and place		25 Sangri	un Roa	d, McHenn		u .
DIV To the Hospital or within 24 hours afte To the Funeral Div completely filled in		Check only	lical Examiner:		of examinatio											
F 3 F 3	Ĕ [2	29b. Signature and title	of certifier	11-		-		29c. Lic			fac-sat	uh-				h, Day, Year)
6	,	0. Name and address of	of person who	ompleted car	JA.	em 23a)	<u>) . </u>		.C.M.	· - .	OGME	-		tober 31,	2012	
V	A)	Theodore M. Ki		•		l Examiner			ltimo	re Street	, Balti	more, N	1D 212	223		
State	e 3	31. Date filed (Month, Da	8 2012		egistrar's Sign	ature hav	1									

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month /0 Physician/ 13:39PM 12 ARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Indian beorge . Date of Birth (Month, Day, Year) Birthplace (State of Foreign Country) 6. Sex **Funeral** 219-12-2838 **Director** 1 M 2 X F 87 3-22-1925 MARYland or 28a-f show 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Brandywine Maryland seorge 10g. Citizen of What Country? Funeral or items 23a 3905 Old 20613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 X Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Retailer 12 and Mental Hygie is marked other 1 and 2 should be filed w of Health and Mental Hygir item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည oroth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Belfield YAULA 129 13905 Old 20613 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or otl cemetery, crematory or other place, 1 X Burial Cremation 3 Removal from State Peters 5 Other (Specify) Waldort 8-12 4 Donation Name and Address of Facility 20608 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. . Approximate Interval Between INFARCTION Immediate Cause (Final MYOCARDIAZ Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perforn death? 2X No 1 🗌 Yes Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending Investigation 2 Accident
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature e of certifier 29d. Date signed (Month, Day, Year) 2012 M 10 Name and address of person who completed cause of death (Item 23a) (Type, Print) 3575 OUD KAMAMAN State

DHMH 17 Rev 06-2011

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ernest Leroy Sunday October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Catherine's Nursing Center Emmitsburg Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F 0772271922 90 Yrs 215-14-2193 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7013 Kelly Store Road 21788 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) was becedent Even Armed Forces? 1 X Yes 2 ☐ No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar If Yes, Give Year or Dates 1942-45 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Be 17. Father's Name (First, Middle, Last) ည Percy Sunday Mazie Portner 19a. Informant's Name/Relationship (Type, Print) Shiela May / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gardens 10-31-12 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and I-transit that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown by signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Records, has been sig ye 2 should b Completed 24a. Was an autopsy page certificate 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: 2 **X**No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: To the Hospital or Attending within 24 hours after death. Natural 5 Pending iniury 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: / 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

16b. Kind of Business Industry Construction 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12902 Hessong Bridge Rd., Thurmont, MD 21788 20c. Location - City or Town, State Frederick, 22. Name and Address of Facility Stauffer Funeral Homes, 104 E. Main St., Thurmont, MD 21788 Approximate Interval Between Onset and Death 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number City or Town, State) 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) Main

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 🗌 Yes 2 💢 No

12:15 A.M

2012

Frederick

Mary Land

14. Race - American Indian,

Black, White, etc.

Specify: White

Registrar

30. Name and address of p

Month, Day,

	Ме	Vlai	
3altimore, MD 21215-0036	dic	080 rk E	
ermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland		m	
Department of Health and Mental Hygiene.		ile	
mportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any			
ijury or other traumatic event, the Medical Examiner must be notified at once.	ral or		
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-08058 ark Emile Smit	th	Please Type or Print in Black Indelible Ink. Ensure All Cop State of Maryland / Department of Health and Mental I		egible.									
		1- For State Certificate of Death		Reg. No. 20	112 3747								
Physicia edical Exami		Decedent's Name (First, Middle,Last) MARK EMILE SMITH	eath Day Yea 2 4, 2012	3. Time of Death 1055 hrs									
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Piney Church Road at Rt. 488 La Plata 4c. County of Death Charles											
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthgard S. Date of Birt											
Director		Usual Residence of Decedent	196	3	Foreign PENN .								
i iow any		10a. State 10b. County 10c. City, Town or Location MD CHARLES WHITE PLAINS			10d. Inside City Limits 1 Yes 2 XXNo								
Maryland 28a-f show d at once.	Director	10e. Street and Number 4224 PARK AVE 20695		10g. Citizen of Wh	-								
with the s 23a or		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	Specify Yes or I	UNITED	STATES - American Indian, Black,								
er death	by Funeral	Armed Forces? 1981 X	to Rican, etc.)	White Specify:	, etc. WHITE								
iours afte hatural? Kamine	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re-	etired)	16b. Kind of Bus	iness/Industry OF JUSTICE								
0036 vithin 72 lene. er than "r	Completed	12TH MASTERS DEGREE TT (INFORMATION TE COMPUTERS	ECH.)	FEDERA	L GOVERN.								
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	WILLIAM A. SMITH GALEEN	J. DU	, Maiden Surname) JRHAM SM									
MD 2 id 2 should lith and M m 27 is m	J D	19a. Informant's Name/Relationship (Type, Print) MICHELE A. SMITH / WIFE 19b. Mailing Address (Street and Number of 4224 PARK AVE., W	HITE B	PLAINS,	MD 20695								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumantic event, the Medical Examiner must be notified at once.			T. Date 29,	20c. Location - RIVER	City or Town, State								
Balti permit. Departm Imports injury o		21. Signature of Funeral Service Licensee TERRENCE L. JOHNSON #M00993 4433 WHITE PLAT	INSON F	UNERAL	SERVICE, PA								
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory a	rrest, shock, or hea	rt Approximate Interval Between Onset and								
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Contact Gunshot Wound of Head Due to (or as a consequence of):			Death								
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause											
ed asit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
e executed cian and irial - trans	اجا	d UNPENDED AMENDED											
8760 rificate b ing physi as the bu	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregr	nancy	23d. Date of delivery Month Day Year									
Box 68760, death certificate be the attending physic ed for use as the bur	Physician/Medica	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) g Unknown											
P.O.	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			oute to the cause of death? Probably 4 Unknown								
ords, w require s been si should b	Completed			opsy pr	ere autopsy findings available for to completion of cause of								
Reco		25. Was case referred to medical 26. Place of Death (Check	1 Yes	formed? de 2 V No 1	eath? Yes 2 No								
Vital hysician this cert	To Be	examiner?	ing Home 5	Residence 6	Other: Scene								
on of ading Pl th. r: After		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 □ Natural 5 □ Pending Pound: 1 □ Yes 2 ✔ No		28d. Describe how injury occurred Subject shot self									
Division of Vital Records, P.O. and or Attending Physician: The law requires that the staff cleath. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined Coperation of the determined Coperation of	or Town,		r or Rural Route Number, City								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transit	Medical Ce	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the ca	use(s) and manner	as stated.								
To with	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signe	d (Month, Day, Year)								
5		30. Name and address of person who completed cause of death (Item 23a)		October 25,	2012								
mx1		Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street,	Baltimore, N	MD 21223									
St Regist	ate rar	31. Date filed (Month, Day Year) 12012 32. Registrar's Signature											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month /O 6:30AM AMES 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death TON Walder CharlES If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) **Director** 0262 1 🔀 M 2 🗆 F 63 1) C 28a-f show 10b. County 10c. City, Town or Location notified at 10d, Inside City Limits Director Woldorf 1 Yes 2 No Maryland 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? an "natural", or items 23a o Medical Examiner must be Funeral 2787 20602 USA permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian was becedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No 1969 If Yes, Give Year or Dates. 1971 Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Black Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene.

item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) IKM 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cobert Stewart MARL Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 10 scoe 10501 20623 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Burial 2 Cremation 3 Removal from State MD) 5 ☐ Other (Specify) 2-12 22. Name and Address of Facility 20608 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Retw Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Etypician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury the attending physician and ched for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the at Id be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes 2 No 3 Probably A Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No After this certificate completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 H No 은 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Vatural 5 Pending 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 only one 29b. Signature, and title of certific 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

av,

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Steele Physician/ Month Oct. Day Laura 2012 Yea 27 09:30 aM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Heartland Health Care Center Hyattsville Prince Georges Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Days Hours 12/18/1924 **Director** 1 □ M 2 □**X**F 579-20-6298 87 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director DC none Washington 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1023 Otis Place, N.W. 20010 or items 23a Funeral U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 ☐ Widowed 4 X Divorced "natural", Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired). Hair Stylist 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Beauty Parlor 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Howard Peterson Hattie Mae Blackwell 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9850 Royal Commerce Placed. 20774 Marsha J. Barnes (Niece) f Health Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery crematory or other place)
Lincoln Memorial 1 X Burial 2 Cremation 3 Removal from State 11/2/2012 Suitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee CC0530 22. Name and Address of Facility Latney's Funeral home 3831 Georgia Ave., NW Washington, 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ larmina disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Month Year Pregnant at time of death
Unknown the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 PNo 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has page 2 autopsy Pascular perform death? phora 1 Yes 2 No Yes 2 No the Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 2 No Other 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director; After this filled in by the funeral di 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month. Day, Year) 75M person who completed cause of death (Item 23a) (Type, Print) Rockville, MD Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 201 Joseph Vincent Shanahan Nov 2:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Stella Maris Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Days 217-30-7471 Director 1 X M 2 □ F 8/1933 Maryland Usual Residence of Decedent Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD. 1 Yes 2 No Harford Baldwin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2535 Greene Road 21013 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. Completed by 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give 3 - Widowed 4 - Divorced Specify: White Korea Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Machine Elementary/Secondary (0-12) College (1-4 or 5+) ege 1 and 2 should be filed with cepartment of Health and Mental Himportant if flem 27 is many injury or other. n and Mental Hygien Machinist Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vincent Bernard Shanahan Anna Livingston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Irma C. Shanahan Greene Road Baldwin, MD. 21013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Nov. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ghview Mem. Gar Fallston. Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland Home. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury Examine Disk to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this contract of the Funeral Director After this contract of the Funeral Director After this contract. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a, Was an death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) **HOSPICE** 1 Yes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner stated (Check 29b. Signature and title

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2012

NOVEMBER

JOSEPH SHANAHAN

DHMH 17 Rev 06-2011

Registrar

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JONES,

1 9 2012

JACKIE

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 13 2012 Physician/ A^{M} Elton Gerald Scafe November 0615 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 Chesapeake City 40 Buddy Boulevard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday **Funeral** Hours Director 383-40-0283 1 🗶 M 2 🗆 F May 5, 1941 Michigan Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Ceci1 Chesapeake City 10e. Street and Number 10g. Citizen of What Country? Funeral 21915 United States 40 Buddy Boulevard 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Armed Force 1 Never Married 2 X Married þ 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Automobile Parts Tractor-Trailer Driver and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other transpore 2 Kelley Maude Wasson Elton Kenneth Scafe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa M. Scafe/Wife P.O. Box 656, Chesapeake City, MD 21915 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Immaculate November 4 Donation 5 Other (Specify) 16, 2012 Cherry Hill, MD Conception Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part & Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Lung Physician/ disease or condition resulting in death) (ancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician ar Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day 1 Yes 2 9 Unknown P.0. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No has 2 X No 1 Yes of Vital 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA ρ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of nours after death.

neral Director: After the funeral of the funeral properties of the funeral p 27. Manner of Death 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Division 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurs Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2

Registrar

29b. Signature and title of certifier

2533 AUGUSTINE

Box 68760

HERMAN HWY, SUITEA, CHESAPEAICE CITY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHA HNAWAZ KHAN ML) (1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ewis Jonas Tice 11:08 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1077 Dorsey Hotel Rd. Grantsville Garrett 5. Social Security Numbe If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 204-16-8498 Director 1 🛛 M 2 🗆 F Jan. 13, 1926 Pennsylvania 86 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔣 No MD Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1077 Dorsey Hotel Rd. 21536 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 K Married ð 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Building Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jonas D. Tice Savilla Yoder 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Tice/Wife 1077 Dorsey Hotel Rd., Grantsville, MD injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mtn. View Cemetery Nov. 12, 2012 Salisbury, PA 21. Signature of Funeral Service 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami or Attending Physician: The law requires that the death certificate be executed r Kinson's attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature nd title of Igned (Month, Day, Year) 1021

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SARAH ALBERTA TESTERMAN :18 AM November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Belair Health and Rehabilitation contr Hartora Belair If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours Min COUNT Months 494 84 7918 220-54-9012 94 1 □ M 2 🔀 F **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a State 10b. County 10c. City, Town or Location at Director notified Forest Hill Harford MD 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 21050 10e. Street and Number ō Examiner must be 23a 315 H. Willrich Circle or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify: "natural", Completed 3 X Widowed 4 ☐ Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname)
Becky Hamm 17. Father's Name (First, Middle, Last) Willy Sexton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig pprox 21050Ή. Darlene Amos/Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1XX urial 2 ☐ Cremation 3 ☐ Removal from State Baptist View Cem. 11/12/12 Jarrettsville,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Inerfal Servi 22. Name and Address of Facility 17314 Harkins Funeral Home, Delta, PA 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on Interval Between Immediate Cause (Final ear Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 9 Unknown ed by the a Unknown s been signed to should be det 23e. Did tobacco use contribute to the cause of death? þ divascula 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an cate has I autopsy death? certificate Yes 25. Was case referred to medical or Attending Physician: 26. Place of Death (Check only one) Be examiner? 2 No Hospital 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manne of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) iniury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying the septactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

on who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

	•	For State Registrar		State C	n iviaryi	anu / t	•	tificate of L			vieritai i iy	Reg. I	0010	37482
Physician		1. Decedent's Nam Margaret		e, Last) .en Umbel							2. Date of De		8, 2012°	3. Time of Death 10:15 A _M
Medica Examine				n, give street and num	nber)			4b. City, Town, or	Locatio	n of Death		_	lc. County of Dea	
		Frostburg Village Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs.						Frostbu		0411		_	Allegany	
Funeral Director		214-42-07	00 _	6. Sex 1 M 2	7. Age (In yi		hday) Yrs.	If Under 1 Year Months Days	Hours	er 24 Hrs. Min.	8. Date of Bi (Month, D April	rth 18,	1927 Per	thplace (State or Foreigr untry) nnsylvania
f show	Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow						ation						10d. Inside City Limits
r 28a						iends	svil	le 10f. Zip Code				10	200	1 🗆 Yes 2 🕱 No
23a o 1st be				lle-Addis	on Rd.			21531				US.	Citizen of What Co A	ountry?
items ner mi		11. Marital Status		12. Was Dece Armed Fo	edent Ever in	_	13. W	as Decedent of H Yes, specify Cuba	ispanic (Origin? (Spe	ecify Yes or No Rican, etc.)		14. Race - Ame	
permit, rage I and 2 should be made which it hous sheel death with the manyand limportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by	1 Never Married 2 Married 3 X Widowed 4 Divorced 1 Yes 2 X No If Yes, Give Year or Dates.				If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ▼ No Specify: Black, White, etc. Specify: White								
n "nat	Completed	15. Decedent's Education (Specify only highest grade completed)			16a.	(Give ki	ent's Usual Occup ind of work done of NOT use retired)		ost of work	ing	16b.	Kind of Business	Industry	
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ntal Hy ed oth	0	17. Father's Name (Last)							_{le (First, Middle} zabeth		,	
nd Me		Norris S. 19a. Informant's Na		hip (Type, Print)		19b	. Mailing	/		-			or Town, State, Zi,	n Code)
ealth a n 27 is ner trai		Richard A	. Umbe					riar Pat						
or oth			☐ Cremation	3 Removal from	State	cemeter	y, crema	ition (Name of atory or other plac	:e)		Date		Location - City or	
artmer ortant injury		4 Donation 21. Signature of Fu			S	teele		netery Name and Addres	ss of Fac				riendsvi al Homes	
Depar Impor any in		D. L.	yre	O pum	au)		O. Box 2						,
nysician/		23a. Part 1. Enter of shock, or head Immediate Cause (disease or condition	ft failure. List : Final	r complications that conly one cause on ea	caused the dinch line.	leath. Do n				t.	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Medical xaminer		Immediate Cause (Final disease or condition resulting in death) a. Loronsry Arten Disease Office office of the consequence of											g	
.	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. — Due to (or as a consequence of):												
physician and the burial-transit	Examiner	Cause (Disease or iinjury that initiated events c. Due to (or as a consequence of):												
ysician e buria				L d										
ling ph e as th	/Mec	IF FEMALE:		000 15 100 014										
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 mpnths? 1								23d. Date of de Month	livery Day Year			
gned by se detac	by Ph	_		ons contributing to d		_		, -	en in Pa	irt I.				the cause of death?
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this ce al direc	ပ္	1 Yes 2			Inpatient 2				4 4				6 Other (Spec	cify)
th. After tunera	cate	1 Natural 2 Accident	5 Pendii 1nvesti	19	of injury th, Day, Year,		ime of njury	28c. Injury work M 1			28d. Describe	how inj	ury occurred	
offer dea	Certificate:	3 Suicide 4 Homicide	6 Could	not be 28e. Place	of Injury - A	t home, far	rm, stree	et, factory, office			28f. Location (City or To			ral Route Number,
hours and ineral I	Medical (29a. Certifier	Certifying	Physician: To the b	est of my kn	owledge, d	death o	ccured at the time	, date an	id place, an	nd due to the ca	ause(s)	and manner as sta	ated.
the Fu	Med	only one) 3	Certifying	Nurse Practioner:				eath occurred at the	e time, d	ate and plac		ne caus	e(s) and manner as	
N VIII		29b. Signature and	title of certifie					29c. License				29d. [Pate signed (Monti	h, Day, Year)
		30. Name and addre	ess of person	who completed caus	se of death (I	tem 23a) (1	Type, Pr	int)	~ 4	7			11/10	012
	2			Broadway			g, M	ID 21532	2					
State Registra		31. Date filed (Monta	n, Day, Year)	12 /32. R	egistrar's Sig	nature	ak							

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November^D09 2012 8:30 рм Ulbrich Bonnie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Frederick Memorial Hospital Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Hours (Month, Day, Year) Director 71 214-38-6932 1 □ M 2 🛣 F 12/8/1940 MD or than "naturel", or items 23a or 28e-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Westminster MD Carroll 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4705 Old Hanover Road 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ۵ Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 ☐ Divorced Specify: Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of William Shook Florence Warfield . Page 1 and 2 should t tment of Health end Me tent: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print)
Deborah Borgoyn/daughter 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 6130 Snowdens Run Road, Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Importent: If ite eny injury or ot 1 Burial 2 X Cremation 3 Removal from State Carroll Cremation 11/13/2012 Hampstead, MD 4 Donation 5 Other (Specify) 22. Name and Address Praints Funeral Home and Chapel, PA 21. Signature of Funeral Service Licenses nec -412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final INFANCTION MYO CANDIAL Physician/ Acule disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician end I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1
Yes 2 24a. Was an autopsy performed? Yes 2 No or Attending Physician: director, 25. Was case referred to medical Be **Division of Vital** 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA hours after death.

nerei Director: After this y filled in by the funeral di 28a. Date of injury (Month, Day, Year) Manner of Deaf 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours a 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Actifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 47951 M 11/12/17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIBTE A KAZMI Tollhouse Ave Frederick MO 21701 31. Date filed (Month, Day, Year) NOV 1 9 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 25 2012 AMELIA LOUISE WILLARD 7:25 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Davs Hours (Month, Day, Year) Director 220-54-3442 67 1 🗆 M 2 🖾 F Sept 4. 1945 Maryland Usual Residence of Decedent or than "natural", or Items 23e or 28a-f show the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Maryland Frederick Thurmont 1 Ves 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21788 13503 Catoctin Hollow Road USA 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc \$ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 No Specify: white Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) machine operator Shoe factory Be permit, Pege 1 and 2 should be file
Department of Heetth and Mental H
Important: If item 27 is marked out 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H ည John Smith Pauline Burkett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin Smith - brother 123 Victor Drive, Thurmont, Maryland 21788 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State Stauffer Crematory 4 Donation 5 Other (Specify) 10-29-2012 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ^{22. Name and Address of Facility} Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ooset and Death Physician/ disease or condition neumon Saus Medical resulting in death) Hive Pulmorary Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the buriel-transit law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page Hospital or Attending Physicien: The 124 hours after death. Funerel Director: After this certificate hetelly filled in by the funeral director, page performed 1 ☐ Yes 2 ☐ No ☐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ျှ 1 📈 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 🗌 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital of within 24 hours a To the Funerel D completely filled in the filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, dots and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ WAGNER JEAN ам BARBARA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Civista a If Under 1 Year If Under 24 Hrs **Funeral** Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Min Hours **Director** 579-54-7829 1 M 2X F SEPT. 26, 1942 WASH., DC 70 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits **Funeral Director** BRYANS ROAD MD CHARLES 1 Yes 2 X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 6615 BUCKNELL ROAD 20616 U. S. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by "natural", or 1 Never Married 2 7. Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 Yes 2 No Specify. Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) AΊ HOME HOMEMAKER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 WALTER J. BAKER HILDA RYCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau WILLIAM F. WAGNER/SPOUSE 6615 BUCKNELL RD., BRYANS ROAD, MD 20616 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State NOVEMBER 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEM.GRDNS. 6, 2012 WALDORF, MARYLAND Signature of Funeral Service 22. Name and Address of FacilityRAYMOND FUNL.SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ incrend らていれん 17 Wacran disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last reavens? Gol isblustana brain tunun physician and is the burial-trans Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death Unknown g Unknown been signed by t should be detack Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy perform 2 🗌 No 1 🗌 Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 2 No ည 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) fter this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1. Natural 5 \square Pending work? within 24 hours after death To the Funeral Director: / Accident 2 🗌 No by the Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10131112

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day,

NOV 20

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ralph Franklin Wachter \mathbf{A}^{M} Medical November 2012 9:20 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Homewood at Crumland Farms Frederick Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days Months Hours (Month, Day, Year) Country 213-18-9040 Director 1 X M 2 □ F 94 Yrs. March 6, 1918 Maryland Usual Residence of Dec ital Hygiene. 3d other then "natural", or items 23a or 28a-f show event, the Mesical Examiner must be notified at 10a, State 10b. Count within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Frederick 1 K Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 310 North College Parkway 21701 United States of America 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1943—
If Yes, Give Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 X Widowed 4 Divorced Specify: Completed White 1978 Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Research Chemist United States Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H pe Charles Newton Wachter Lucy Estelle Neidhardt permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke eny Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Wachter / Son 12438 Stottlemver Road, Myersville, Maryland 21773 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State November 19, 4 Donation 5 Other (Specify) Frederick, Maryland Saint John's Cemetery 2012 Signature of Funcial Vervice License 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between peach lin shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Exami Hospital or Attending Physician: The lew requires that the death certificete be executed 24 hours after death.

Funeral Director: After this cartificate because the death. for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform 2 No No 1 🗌 Yes within 24 hours after death,

To the Funerel Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 Hospital <u>۾</u> 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 🗌 Yes Accident М 2 🗌 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check To the within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and License number 29d. Date signed (Mgnth, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

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300 West Ninth Street, Frederick, Maryland 21701

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's §

Robert Kauffman, M.D.

NOV 2 0 2012

31. Date filed (Month, Day, Yea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 17, Joh<u>n Orville Wade Jr</u> 2012 9:58 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 214 Glen Ave. Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 04/27/1935 **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours **Director** 294-30-0764 1 XM 2 F 77 Ohio iral", or items 23a or 28a-f show Ex-miner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Fermines mand be actived. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 214 Glen Ave. 21804 USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 😾 Married Black, White, etc. þ 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Agent Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Orville Wade Sr. Julia Reidv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie C. Wade / Spouse 214 Glen Ave., Salisbury, MD 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Wicomico Mem. Park 09/20/2012 Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Rena Immediate Cause (Final Physician/ Metastatil Concer disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for not not the funeral director, page 2 should be detached for not not the funeral director. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 😡 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🎛 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Certificate: To 1 ☐ Yes 2 ☐xNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title of perti 026278 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year) NOV 0 2 2012

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Registrar's Signa

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	_		Registrar 1. Decedent's Name (First, Middle, Last)		eath		Reg. No. 2	112	37488			
	Physicia	n/		vard Victor		2. Date of De Month Novemb	Day	2012	3. Time of Death			
nadi,	Medic Examin		4a. Facility Name (if not institution, give si		ocation of Death	Movemb		ty of Death	2030 F ···			
mar of			Calvert Manor Hea	Sun			eci1					
M	Funeral			cial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Ur Months Days Hou						9. Birthp Coun	place (State or Foreign htry)	
1	Director		173-10-7919 Usual Residence of Decedent	M 2 □ F 95	Yrs.			OCT 17	, 1917	Penn	sylvania	
	shov d at	to	10a. State 10b. County	100	. City, Town or	Location				1	10d. Inside City Limits	
	Mary 28a-f otifie	Director	Maryland Cecil		North						1 ☐ Yes 2 🔀 No	
	th the 3a or t be n		10e. Street and Number			10f. Zip Code			10g. Citizen o		•	
	ath w	Funeral	138 Watson Way	12. Was Decedent Ever in	n U.S. 113	21901 B. Was Decedent of His	nanic Origin? (Spe	ecify Yes or No-		ed St		
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Forces? 10	943 - 1946	If Yes, specify Cuban 1 ☐ Yes 2 🏋 No	Mexican, Puerto	Rican, etc.)	ВІ	14. Race - American Indian, Black, White, etc. Specify: White		
5-0	2 hour "natu dical	Completed	15. Decedent's Edu (Specify only highest grad			cedent's Usual Occupat re kind of work done du		ina	16b. Kind of			
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d 2	led wi Hygie other ent, ti	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First. Middle		ıfactu me)	TING	
<u>lan</u>	should be filed and Mental Hyger is marked other raumatic event.	To	Martin Wintczak					e Brezi		,		
lan	should and N is ma auma		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Ma	iling Address (Street an	nd Number or Rura	al Route Numbe	er, City or Town,	State, Zip (Code)	
€,	and 2 s Health tem 27		Eleanor Wintczak-McNe			Watson Way	, North	East,				
Jore	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	Db. Place of Dis Saints	position (Name of ematory or other place) Peter and metery	Nove		20c. Location	•		
Ħ.	nit. Pa artme ortani injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signatule of Funeral Service Licensee		Paul_Ce	metery 22. Name and Address	16,				ld, PA	
B	permi Depar Impor any ir		Doney S.	a diel &	- 4		Stockton					
ı	Other Park and		23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one Immediate Cause (Final		death. Do not e	_			rest,		Approximate Interval Between Onset and Death	
	Physician/ Medical		disease or condition resulting in death)	Due to (or as a cons	sequence of):	Cardion	10 bocco	4		-	years	
	Examiner	_	Sequentially list conditions,									
	d sit	Examiner	cause. Enter Underlying	Due to for sels diconecquence oi)								
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0	icate be executed physician and is the burial-transit	edical										
Box 68760	ifficate ng phy as th		IF FEMALE;	•								
9 ×	th cert tendir or use	ian/i	23b. Was decedent pregnant in the past 12 months?		Fetal death 3	Ectopic pregnancy				Date of delive		
. B	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/M	1 Yes 2 No	4 ☐ Pregnant at time g ☐ Unknown	of death 5	Other (specify)				1onth	Day Year	
P.O.	that the	by Pr	Part II. Other significant conditions con	_	t resulting in the	underlying cause give	n in Part I.	23e. Did t	obacco use cor	ntribute to th	ne cause of death?	
ds,	requires been sign should be	edk	Cerebral I	-nfarcts				1 🗆	Yes 200No	3 🗌 Prob	pably 4 🗆 Unknown	
COL	aw rec as be	Completed	-					24a. Was auto		. Were autop	psy findings available mpletion of cause of	
Be	'sician: The law r s certificate has b director, page 2 s							1 Yes	ormed? 2 XI No	death?	2 □ No	
İta	sician certifi irector	Be o	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	ospital:		Other	ce of Death (Check					
<u></u>	ding Physician: h. After this certific funeral director,	e: To	27. Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Time	of 28c. Injury a	4 Nursing Ho		dence 6 🗆 Ot now injury occu)	
on (ending kath. rr: Afte he fun	icat	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year	r) injury		es 2 🗆 No		, ,		I.	
Division of Vital Records,	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	at home, farm, s	treet, factory, office		28f. Location (S	Street and Num	ber or Rural	Route Number,	
	pital o		29a, Certifier 1 Certifying Physic	ian: To the best of my kr	anuladas dask	a consisted at the time.	dete and place as				1	
	To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check 2 Medical Examine	er: On the basis of examination of the basis of examination of the best	ation and/or inve	estigation, in my opinion,	death occurred at	the time, date a	and place, and d	lue to the cau	use(s) and manner stated.	
	To th within To th comp		29b. Signature and title of certifier		,	29c. License n			29d. Date sign			
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	MYIM		30. Name and address of person who cor	A 1 C		1.2.		. N	10 2	1911		
	Stat	e	31. Date filed (Month, Day, Year)	32, Registrar's Signature	gnature _	i Way, R	131 rg	MA, I	ID &	1111		
	Registra		NOV 1 9 2012	Brento B	. par	las						

Please Type or Print in Black Indelible Inks Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year CLARENCE Month 4:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7702 Wynbrook Rd. Baltimore N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) 217-36-8671 Director 1 □ M 2 □ F 73 Yrs. 09/03/1939 MD Usual Residence of Deceder or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7702 Wynbrook Rd. 21224 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8th College (1-4 or 5+) N/A N/ABe 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17, Father's Name (First, Middle, Last) ၉ Clarence Allen -Lewis 19a. Informant's Name/Relationship (Type, Print **Friend** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvin Francis (Nephew) 7702 Wynbrook Rd. Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 11/24/12 5 Other (Specify) On-Site Crematory Baltimore, Funeral Service License ^{22. Name and Address} of Facility Joseph H. Brown, Jr 2140 N. Fulton Ave. Signature Funeral Home PA Balto., MD 21217 Jr. Balto., 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

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Due to (or see a consequence of the cause of t Approximate Interval Between Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. the Puneral Director: After this certificate has been signed by the attending physici P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, · 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 2 X No ည 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29b. Signature and title of certife 29c License number 29d. Date signed (Month, Day, Year) DO067635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

JHBMC

. Registrar's Signa

COLBURN

31. Date filed (Month, Day, Year) NOV 2 6 2012

4940 EASTERN AVE. BALTIMORE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4c. County of Death acilityName (if not institution, give street and nu or Location of Death **Examiner** If Under 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign **Funeral** Min. 07-23-1954 St. Kitts 578-13-1567 Director 1 🛛 M 2 🗆 F 58 10c. City, Town or Location 28a-f show 10d. Inside City Limits 10a. State 10b. County Examiner must be notified at Director MD PG 1X Yes 2 No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1204 Torington Pl. 20774 USA , or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 72 hours after 2 😾 No Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: Specify: and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) High School Teacher **PGCPS** Be 18. Mother's Name (First, Middle, Maiden Surname)
Sybyl Warner 17. Father's Name (First, Middle, Last) ပ္ Winston Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1204 Torington Pl. Largo, MD 20774 Sandra Allen/Wife Department of Health an Important: If item 27 is any injury or other trau Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Pk Crematory 11-30-2012|Riverdale, MD 22. Name and Address of Facilit Ronald Taylor II Fh Signature of Funeral Service Licensee 10583 Middleport Ln. White Plains, MD 20695 hal caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or each line. . Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final eukemia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to himmediate Examine cause. Enter Underlying Cause (Disease or injury -transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown g Unknown signed by I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown Records, 1 Yes should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy 1 Yes 2 No Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Tyes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manny of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred I Director: After to a in by the funeral Certificate: (Month, Day, Year) 5 Pending Natural 2 Accident Investigation Suicide 6 Could not be 28f, Location (Street and Number or Rural Route Number 28e. Place of Injury - At home, farm, street, factory, office filled in by 4 Homicide determined building, etc. (Specify) City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of centifier 29b. Signature November 18, 2012 785-000 and address of person who completed AJAR KOCHAR 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

NOV 26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year 2012 David H. Alden 11:15 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min **Director** 1 X M 2 D F 87 155-18-6569 2-4-1925 New York ir then "neture!", or items 23e or 28e-f shov the Medical Examinar must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral #MG609 20904 United States 3142 Gracefield Road deeth v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1943 ģ 1 Y Yes 2 ☐ No If Yes, Give within 72 hours efter Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 D Widowed 4 Divorced 1945 Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Pege 1 and 2 should be filed within 72 ment of Heeith and Mantei Hygiane. ant: if item 27 is merked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Salesman Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rita David Ginsberg Emanuel Galland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9206 Overlea Drive, Rockville, Maryland 20850 Michael Gordon – Son-in-law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Pege 1 ¢
Depertment of I
Important: if ite
any injury or ot Date 20c. Location - City or Town, State 1 🎾 Burial 2 🗋 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) B'nai Abraham Memorial Park 11-16-2012 Union, New Jersey Signature of Funeral Service Licensee 1101477 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike, Rockville, Maryland 20852 Kurt Blake 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia resulting in death) Medical Due to (or as a consequence of): [‡]Examiner YEARS Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): rsicien end 9 buriei-trensit Hospital or Attending Physicien: The lew requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last ttending physicien for use as the burie Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death Yes 2 □ No After this certificete hes been signed by the signerel director, page 2 should be deteched 9 I Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Division of Vital Records, Congestive Heart Disease 1 🖾 Yes 2 🗆 No 3 🗆 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No 2 🛛 N 1 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 ☒ No 1 🛛 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 24 hours after deeth.
Funerei Director: After this etely filied in by the funerel 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and Medical To the Hosp within 24 hou To the Funer completely fi 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

arks

Eugenio Machado, MD - 3110 Gracefield Drive, Silver Spring, Maryland 20904

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 2

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D24035

11-14-2012

Please Type or Print in Black Indelible Ink. Ensure All Conjes Are Legible. amend items 20b per fh,26 per doc g933 11-26-12 vt State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Roy Anderson 2:20 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death timore on If Under 24 Hrs. rs. last birthdav) Year 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours Min Director Usual Residence of Decedent 28a-f show or items 23a or 28a-f shorminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MI 1 Yes 2 No Limore 10e. Street and Number 10g. Citizen of What Country? Funeral and 21218 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced lack Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) f Health and Mental Hygiene. Item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ 4nders un COV formant's Name/Relationship (Type, Prifit) 19b. Mailing Address (Street and Number o<u>r Bu</u>ral Route Number, City or Town, State, Zip Sister 45 Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o Knietery crematory or other 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Limore 73-2012 Sal laughn C. Greene Funeral Services Signature of Funeral Service Licenses 22. Name and Address of Facility 905 MD 21212 imore au 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ gastic Starc adenocaranoma disease or condition apprex 14-car Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Pregnant at time of death Year 2 No the 9 Unknown Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, berlension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown perchlosestislenia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law this certificate has by ral director, page 2 s autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ✓ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tyes 2 🖊 No ဂ္ဂ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 A Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending Accident Investigation Suicide 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 11/19/2012 00067651 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Goso Falls Rd, Svite 204 Baltimore MD 21209 MD GHAFOOR HIMA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 6 2012 Registrar

12-08847 Earl August Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Di	epartment of Certificate of		tal Hygiene Reg	No. 2012	37493
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Earl Michael August			2. Date of Death Month I November 2)av Year	3. Time of Death 0710 hrs
The state of the s	4a. Facility Name (if not institution, give street and number) Howard County General Hospital	41	b. City, Town, or Location of		4c. County of Death	
Funeral	•	yrs. last birthday)	If Under 1 Year If Under		(MM/DD/YYYY) 9. Birth	place (State or
Director	213-54-8998 1X M 2 F Usual Residence of Decedent	54 Yrs.	Months Days Hours	Min. 7–16–	1958 cou	ntryIllinois
w any	10a. State 10b. County 10c.	City, Town or Location				10d. Inside City Limits
4aryland 128a-f show 1 at once. ector	MD Frederick 10e. Street and Number	Frederic	10f. Zip Code	100	. Citizen of What Count	
h the Maryland 3a or 28a-f sh lotified at once	2627 Monocacy Ford Rd		21701		nited State	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Jan.: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medis at Examiner must he notified at once or other traumatic event, the Completed by Furneral Director	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X	No If Ye	Decedent of Hispanic Orig es, specify Cuban, Mexican		14. Race - Americ White, etc.	
irs after tural", o miner i	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	ted) 16a. Decedent	Yes 2 X No specify: 's Usual Occupation (Give		Specify: White 16b. Kind of Business/In	
5-0036 ed within 72 hour typgiene. other Hand "natu the Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+) 5+		st of working life. DO NOT ientist	·	Nat'l Cance	er Inst.
MD 21215-0036 nd 2 should be filed within 7 alth and Mental Hygiene. m 27 is marked other than a unmatic event, the Mediananic event	17. Father's Name (First, Middle, Last)		18.Mother	's Name (First, Middle, Ma		
2121 ould be fill ould be fill ould be fill ould be fill ould be fill s marked tic event,	Marvin August 19a. Informant's Name/Relationship (Type, Print)	1	Address (Street and Nun			
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Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	crematory or oth Crem. Cen	er place) ter of MD	11/24/12	Hanover, 1	
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and Iv Important: If item 27 is m injury or other traumatic. To	21. Signature of Funeral Service Licensee	22. N	ame and Address of Facility	Harry H. Wi mbia Pike El	tzke's Fam licott Cit	ily FH, Inc y MD 21043
Physician	23a Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.			ardiac or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atheroperature		ovascular Disease			Death
Jer Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence)	ence of):				
ted Insit Examiner	cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last	ence of):		<u> </u>		
execur an and al - tra	d				<u> </u>	
68760, certificate be nding physicia se as the buristian/Medi	IF FEMALE: 23c. if yes, outcome of 1 Live birth		tal death 3 Ectopi	c pregnancy	23d. Date of delivery Month D	ay Year
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funceral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the telescal Certification: To Be Completed by Physician/IM	past 12 months? 1 Yes 2 No 9 Unknown g Unknown	o of dooth	ner (Specify)			
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for ur	A	ut not resulting in the u	nderlying cause given in P		pacco use contribute to	
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Division of Vital Records, P.O. tall or Attending Physician: The law requires that the state death. To Director: After this certificate has been signed by led in by the funeral director, page 2 should be deace erification: To Be Completed by F.				perform		
ital Ficial: s certification; Be C	25. Was case referred to medical examiner? Hospital: 1 Inpatient	2 ✔ ER/Outpatient	Others	(Check only one) Nursing Home 5	Residence 6 Other	
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ision Attendi or death. rector: by the f	1 V Natural 5 Pending 2 Accident Investigation 28e. Place of Injury	y - At home, farm, stree	1 Yes 2 et, factory, office building, e		treet and Number or Ru	ral Route Number, City
Division o Hospital of Attending 24 hours after death. Funeral Director: Afte reely filled in by the fune ral Certification:	3 Suicide 6 Could not be determined (Specify)			or Town, St		
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director. Medical Certification: To Be (29a. Certifier 1 Certifying Physician: To the best of my kr one) 2 Medical Examiner: On the basis of examin and manner stated.	nowledge, death occur nation and/or investigat	red at the time, date and p tion, in my opinion, death o	lace, and due to the cause ccurred at the time, date a	e(s) and manner as state and place, and due to th	ed. e cause(s)
F 3F 8	29b. Signature and title of certifier	in	29c. License number O.C.M.E.		29d. Date signed (Mo. November 21, 20	
	30. Name and address of person who completed cause of deat	th (Item 23a)				
State	Carol H. Allan, MD Assistant Medical Exal 31. Date filed (Month, Day, Year) 32 Registrar's	Signature		timore, MD 21223		
Registra	0.0000	1. par	Keed			

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 0 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Baltimore Highlands 3012 Florida Avenue Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days (Month, Day, 1 X M 2 - F Hours Min 215-24-9115 86 **Director** Oct. 1926 Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits must be notified at Director Baltimore Highlands 1 Yes 2 X No MD Raltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 21227 USA items 23a 3012 Florida Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian or than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Milk Man Delivery of Health and Mental Hygi item 27 is marked other other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Esther Hodges Henry Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau Helen Allen / Wife 3012 Florida AVenue Baltimore Mighlands 21227 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Atlantic Crematory Nov.21,2012 Glen Burnie, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscleration Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Dia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of HTN burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death signed by the a ld be detached f Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires twithin 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. injury at 28d. Describe how injury occurred Certificate: Natural injury work?
1 Yes 2 No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Thomas

31. Date filed (Month, Day, Year)

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NUV 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:10 am Hanna Blume Aranovich November Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 10921 Inwood Avenue. #227 Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 216-45-0288 Director 1 🗆 M 2 🖎 F 91 11/04/1921 Estonia an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location Director Silver Spring 1 Yes 2 No Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral U.S.A. 10921 Inwood Avenue, #227 20902 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify 3 X Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 91 end 2 should ba filed within 72 nc. of Health and Mental Hygians.
If Item 27 is marked other than "no. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aaron Eidelkind Sheina Libesman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 916 South Belgrade Rd., Silver Spring, Maryland 2090 Adir Aronovich - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State parmit. Pege 1 e Dapartment of H Important: If Ite any Injury or ot 1 X Burial 2 Cremation 3 Removal from State Garden of Remembrance 11/25/2012 Clarksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) re of Fundal Service L 21. Signa 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Malignant Neoplasm of Uterus w/Metastatic Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (of as a consequence of) inding physician and use as tha buriel-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at the control of the 23b. Was decedent pregnant 23d. Date of delivery for u 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year signed by the at Id ba datachad fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Aftar this cartificata has infunaral director, paga 2: autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🕱 No To the Hospital or Attending Physicien: "
within 24 hours aftar death.

To the Funaral Director: Aftar this cartifics complataly filled in by tha funaral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔯 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D35579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8218 Wisconsin Avenue. #305, Bethesda, Maryland 20814 Susan J. Miller, M.D.,

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death November 22, Physician/ 2012 8:17 P M Robert Alban, Jr. Earl Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days 216-28-1174 80 Director 1X1M 2 □ F Nov. 28,1931 Maryland 28a-f show 10b. Count 10c. City, Town or Location 10d. Inside City Limits nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f sho: or other traumatic event, the Medical Examiner must be notified at Director 1 Tes 2 No Lutherville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 U.S.A. 8411 Saunders Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married If Yes, Give 053-1965 Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Dentist Dentistry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Catherine Shuman Alban, Sr. Earl Robert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8411 Saunders Road Lutherville, Maryland Earl Robert Alban, III Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp.: 11-27-2012 Towson Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice 22. Name and Address of Facility Ruck Towson Funeral Home, Towson, Maryland 1050 York Road 23a. Part 1. Enter the disease, or complicat ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. this certificate has been signed I al director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No rs after deau... rai Director. After this cerum... in by the funeral director, p. Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other:
4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical 1 Certifying Physician: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1)0071287 30. Name and address of person who sampleted cause of death (Item 23a) (Type, Print) 20+1

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day, Year)

NOV 2 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ BASTFIELD PM 22 2:30 2012 NOVEMBER GERALDINE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDAUSTOWN BALMMORE NORTHWEST HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 M 2 X F Months Days Hours 1274677925 219-16-1925 MD **Director** 86 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County notified at Director MD N/ABaltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. 'is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be r Funeral 21215 4105 Boarman Ave. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc by 1 Never Married 2 Married Yes Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. Black If Yes, Give Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16b. Kind of Business Industry Center 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)
4 Yrs filed within Waxter's Children Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) permit. Page 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or con-ည Minnie James Alex Clark pe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7816 Liberty Rd. Baltimore, MD 21244 Kathy Edwards (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site Crematory 12/3/12 Baltimore, MD Joseph H. Brown Jr. 2140 N. Fulton Ave. 21. Signature | Funeral Service Licensee Funeral Home PA Balto., MD 21217 Þ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDIAL INFARCTION disease or condition ACUTE Medical resulting in death) Due to (or as a consequence of) Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, Isaaling to immediate cause. Enter Underlying Cause (Disease or iinjury Examine the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Other (specify) signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an ate has bage 2 s autopsy performed? death? 1 Yes 2 No After this certificate 25. Was case referred to medica 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury 24 hours after death. Funeral Director: Al Investigation Accident filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check within 2 To the F only one) 29d. Date signed (Month, Day, Year) 29b. Signatu D0060293 22, 2012 NOVEMBER

Registrar
DHMH 17 Rev 7/2009

State

park

5401

OLD COURT RD

RONDALLSTOWN

21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

AHMED,

MURTUZA

31. Date filed (Month, Day, Year)

NOV 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 5:30 PM Daniel Beck F. 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPita Baltimore Franklin Square Rosedole Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) 11/27/1948 Country)
Maryland Days Hours Director 217 56 7627 1 🛛 M 2 □ F 63 Vre Usual Residence of Decedent Pege 1 and 2 should be filed within 72 hours efter death with the Maryland ment of Health end Mental Hygiene. ent. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21221 2358 Schaffers Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. à 1 Never Married 2 N Married 21215-0036 Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work dane during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Commercial Fishing Owner / Operator Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mae M. Velte Daniel F. Beck Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2358 Schaffers Road Essex Maryland 21221 Joyce Beck (wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Importent: I any injury o Bayview Crematory Inc 11/28/2012 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) S 22. Name and Address of Facility Bruzdzinski Funeral Home PA Furieral Service 1407 Old Eastern Avenue Essex Maryland 21221 23a. art . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s oc , or heart failure. List only one cause on each line.

Immediate Cause (Final disease for condition resulting death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death ₽hysician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifier 29c. License number D36663 11/23 5015 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stuart 9000 Franklin Square Drive Baltimore ma 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Beck

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 1 perpHYS, G933, 11/26/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eldora Barron Year Month 0152 Lota Basson November Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Randallstown Northwest Hospital Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Director 219-70-2426 54 0^M1^m1^m3^m/1^m958 MD Usual Residence of Decedent or 28a-f show with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Windsor Mill 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 2521 Elsemere Dr. 21244 U.S.A. permit. Page 1 and 2 should be filled within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mus once. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Northwest Hospital Yrs. Dietitician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Barron Mattie Clemons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
511 Piney Run Ct. Sykesville, MD 21784 James Hamlin (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Buria 2 Ocremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 11/27/12 On-Site Crematory: Baltimore, MD 21. Signature of Funeral Service 2 Joseph H. Brown Jr. 2140 N. Fulton Ave. Funeral Home PA acquelint MD 21217 Balto., 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ dysthythmia disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) law requires that the death certificate be executed hypertersia been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24a. Was an 24b. Were autopsy findings available this certificate has prior to completion of cause of death?

1 Yes 2 No autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗆 Yes 2 🗷 No Other: ပ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nulse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 15,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Northwest dewit MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NANCY HANNA BISSELL 10:22A M 2012 OVEMBER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 217-62-4896 Director 1 □ M 2 🕅 F 63 May 19, 1949 Macyland Usual Residence of Deceder er then "neturel", or items 23e or 28e-f show the Medicel Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Maryland Baltimore County Timonium 1 ☐ Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 21093 Funeral 2525 Pot Spring Road, S-321 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black White etc. 1 XNever Married 2 Married il Hyglene. other then "neturel", or δ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Voluntear 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Charity Groups Be Bissell, Nancy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H John Littig Bissell pe Macy Patricia McKenna permit. Page 1 end 2 should be Depertment of Health and Ment Importent: If Item 27 is marke eny injury or other treumetic' 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 Pot Spring Road, Timonium, MD 21093 Suzannah Bissell (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Jos. Ch Cemetery 12/28/2012 Cockeysville, Maryland 21. Signature of Funeral Service Liberisee MITCHETT WIFDEFELD FUNERAL HOME, INC 6500 York Road, Baltimore, Macyland 21212 Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Kespinatony disease or condition Medical resulting in death) Due to or as a consequent e of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury sicien end burial-transit or Attending Physicien: The law requires that the death certificete be executed ongestive eur that initiated events Due to (or as a consequence of): resulting in death) Last ng physicien es the burial Physician/Medical P.O. Box 68760 ettending p IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Tunknown been signated to should to 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate hes b director, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 N hin 24 hours after death.

the Funerel Director: After this certific

mpletely filled in by the funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work?
1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospitei Medical 29a. Certifier 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2.
To the F only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 8550 Rulian use of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year State NOV 2 6 2012 Registrar